UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN
* * * * *

GREGORY BOYER, as Administrator of the Estate of Christine Boyer, and on his own behalf,

Plaintiff,

vs. Lead Case No.: 20-CV-1123

ADVANCED CORRECTIONAL HEALTHCARE, INC., et al.,

Defendants.

GREGORY BOYER, as Administrator of the Estate of Christine Boyer, and on his own behalf,

Plaintiff,

vs. Case No.: 22-CV-723

USA MEDICAL & PSYCHOLOGICAL STAFFING, et al.,

Defendants.

VIDEOCONFERENCE DEPOSITION OF JEFFREY KELLER, M.D., FACEP, FACCP

Tuesday, March 19, 2024; 10:00 o'clock a.m.

BE IT REMEMBERED that the videoconference deposition of JEFFREY KELLER, M.D., FACEP, FACCP, was taken by the attorney for the defendants at the office of T&T Reporting, 477 Shoup Avenue, Suite 105, Idaho Falls, Idaho, before DiAnn Erdman Prock, CSR SRL 963, CCR, Court Reporter and Notary Public, in and for the State of Idaho, in the above-entitled matter.

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I N D E X
E X A M I N A T I O N

I N D E X
E X H I B I T S

EXHIBITS 88 & 90 RETAINED BY COUNSEL

(The deposition proceeded at 10:00 a.m. as follows:)

WHEREUPON,

JEFFREY KELLER, M.D., FACEP, FACCP, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

* * * * * *

EXAMINATION

BY MR. KNOTT:

Q. Good morning, sir. Could you please state your name for the record?

A. Jeffrey Ernest Keller.

Q. And you're a medical doctor?

A. Yes.

Q. And you're board certified in emergency medicine; is that true?

A. Yes.

Q. And my understanding is that you have no other board certifications, correct?

A. Correct.

Q. And, sir, my name is Doug Knott, and I represent Advanced Correctional Health Care and Nurse Practitioner Pisney and Nurse Fennigkoh.

Do you understand that?
A. Yes.
Q. And do you understand that I'm here to take your deposition and talk to you about the opinions that you've rendered that bear on my clients?
A. Yes.
Q. Do you understand that?
A. Yes.
Q. And I received a report dated February 7, 2024, that I'm told contains your opinions relevant to the matter; is that true?
A. Yes.
Q. Is that your complete and final statement of opinions?
A. Yes.
Q. Can we rely on your written report as introducing and explaining your opinions relevant to the matter?
A. Yes.
Q. And we were given your curriculum vitae as well, and I think that's dated June 20, 2023.
Are there any significant changes to your curriculum vitae since June 2023?
A. The only significant change is that I am

now the president of the American College of Correctional Physicians rather than the president elect.
Q. Thank you.
And when did your term start, and when does your term end?
A. My term started the first week of September, and it will end in two years from then.
Q. And how long have you been a member of the Board of the American College of Correctional Physicians?
A. I've been the member of the board for approximately eight years.
Q. Are there any physicians employed by Advance Correctional Health Care on the board of the American College of Correctional Physicians? Do you know? Do you know?
A. No. There are not.
Q. Are you familiar with any physicians that are employed by Advance Correctional Health Care?
A. No. I may be, but I can't think of any off the top of my head.
Q. Right. Fair enough.
So far we can hear each other, and we're

communicating okay. Just because of the technology and because of the way I ask questions, sometimes I trail off. Please recognize that, and try to wait for the end of my question.
I recognize that the way I ask questions can be difficult because I change direction in the middle, but let's try not to speak over one another. And if we do, we'll try to make it clear for the record.
Okay?
A. Okay.
Q. So you're located where at the moment, sir?
A. I am in Idaho Falls, Idaho.
Q. And you're located in the court reporter's office there, correct?
A. Yes.
Q. And the court reporter is located with you, correct?
A. Yes.
Q. And there's no one else in the room?
A. No.
Q. And did you meet with anybody by Zoom, in person, or telephone to prepare for the deposition?

A. I met with Mr. Weil yesterday.
Q. And how long did you meet with him?
A. About six hours.
Q. And was that by Zoom?
A. Yes.
Q. And have you had previous Zoom meetings with Mr. Weil?
A. Relevant to this case, yes.
Q. How many?
A. I'm not sure. Most of our communications have been by phone, but we've had a couple of Zoom meetings, so maybe two.
Q. And approximately how many phone calls have you had with Mr. Weil about the case to date?
A. Five-ish.
Q. And, sir, you were asked to bring certain things to the deposition, correct?
A. Yes.
Q. And were you shown a Notice of Deposition that had a duces tecum or list of things that we asked you to bring to the deposition?
A. Yes.
Q. And we asked you to bring your entire file on which you formed the basis for your opinions, correct?

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A. Yes.
Q. And you didn't do that, correct?
A. I went over -- we went over that list of documents to bring to the -- to the deposition, and Mr. Weil said he would handle some things, and I said I would -- and asked me to bring other things, and I brought everything I thought I was assigned to bring.
Q. Obviously, you reviewed a lot of medical records?
A. Yes.
Q. And you -- did you review those medical records on PDF?
A. Yes.
Q. Did you print at any time medical records that you reviewed in the case?
A. No. Not that I recall.
Q. And so do you work off a laptop when you review medical records for this type of work?
A. I have a laptop and a desk top, and I use both.
Q. And you're capable of reviewing the records that you reviewed in this case on the laptop if necessary, right?
A. Yes.

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Q. Did you bring the laptop to the deposition?
A. No.
Q. Were you told not to bring the laptop to the deposition?
A. No. I was not told not to bring the laptop.
Q. So you know that we're going to be talking about more than twenty inmates today. If I ask you questions about particular facts and circumstances of those inmates, you would not be able to reference the record and identify by page number, or any other way, the source of the facts that you're asserting, true?
MR. WEIL: Object to form.
THE WITNESS: No. I do not have the original medical records with me. I have only my report.
Q. (BY MR. KNOTT:) Is it fair to say, as you sit here today, you don't have a sufficient recollection of the facts on each and every case such that you could testify to a reasonable degree of medical probability about those facts?
MR. WEIL: Object to form.
THE WITNESS: I have my report, and that

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is -- that is my -- that's my report after reviewing the records.
Q. (BY MR. KNOTT:) And your report doesn't cite to Bates numbers for the facts that you assert, correct?
A. Yes.
Q. So if I ask you the source of a fact that you've asserted in your report, you would not be able to locate it in order to explain your opinion, true?
MR. WEIL: Object to form.
THE WITNESS: I would not be able to show the source of particular statements, correct.
MR. KNOTT: Well, I object to proceeding with a deposition where the witness has not brought the materials requested and is unable to have a dialogue about the source of facts with respect to these more than twenty witnesses that he's -- are inmates that he's going to discuss, so --
MR. WEIL: Doug, do you want to discuss that right now, Doug, or -- the documents that were provided to Dr. Keller are predominantly drop boxes so on my Dropbox. We can provide those -- the documents we sent you have links to those drop boxes, and so they're all accessible to you now, and

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that's the method by which we're providing the documents you're requesting.
So if Dr. Keller has a screen, he could look up any document that you're asking about in the records we've provided.
MR. KELLER: But he's not able to locate a record if I ask him to in his file, which is the purpose of the request, you know.
Dr. Bentley sat there with the report in front of her and couldn't speak to the facts of the case in order to give us sources, and I think that was an unfair situation for us, and I think you've put us in the same situation.
The Notice of Deposition doesn't ask that he bring -- that you provide it to me. It asks that the witness have it with him at the deposition.
MR. WEIL: And I think in the context of an online deposition like that that's a little -- that's fairly unclear in the situation. I mean, we could go off the record and figure out if there's a computer that we can send the link to Dr. Keller, and he can just look at the pages there on the Dropbox.
As you know, there are thousands of pages of records. I don't know if you expected

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Dr. Keller to print every single page out and come down with boxes of documents or what --

MR. KNOTT: I expected Dr. Keller to have some facility in locating, in identifying the factual basis for some of his statements, so --

MR. WEIL: In an online situation like that, that's a little unclear here. I think -- I'll let you finish, Doug.

MR. KNOTT: Is there a laptop that the doctor can locate, or should we adjourn this and continue when he's got access to the records that he's going to be citing.

THE COURT REPORTER: Counsel, can we go off the record?

(A brief recess was had.)

MR. KNOTT: Let's go back on the record.

Well, we took a break while the court reporter located a laptop, and we have been working through the process of Dr. Keller getting access to the Dropbox links with the medical records relevant to the case.

Q. (BY MR. KNOTT:) By the way, Doctor, what time is it there?

A. It is 10:34 a.m.

Q. And my understanding is that your

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deposition was noticed for 10:00 a.m. Central.

Did you receive a notice that said it was scheduled for --

A. Well, I -- whether I made a mistake or not, I thought it was scheduled for 10:00 a.m. my time.

Q. Gotcha.

All right. I just want to make sure that we note that in case there's an issue down the road.

So, Doctor, my understanding from our brief conversation before the deposition started was that you brought your report into the room, right?

A. Yes.

Q. And you brought Dr. Bentley's report?

A. Yes.

Q. And can you tell me the date of Dr. Bentley's report?

A. Dr. Bentley's report is dated February 2nd, 2024.

Q. And you brought with you to the room an invoice for your services?

A. Yes.

Q. Is that the only invoice you've issued to date?

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A. Yes.

MR. KNOTT: And we'll have that marked. I think we're up to Exhibit 88.

(Exhibit 88 was marked for identification.)

Q. (BY MR. KNOTT:) Can you tell me when you first started work on the matter, Doctor?

A. About a year ago.

Q. Does it have a date on your invoice?

A. The first date on the invoice is 2-11-23.

Q. And can you tell me the amount of your charges so far?

A. Nineteen thousand, two hundred and fifty dollars.

Q. And what is the date of your invoice?

A. February 12th, 2024.

Q. And has the invoice that you've been issued been paid?

A. No.

Q. Do you have some agreement with plaintiff's counsel on the timing of payment?

A. I received an e-mail a couple of days ago saying that they -- it had been approved for payment, but that I had -- they didn't have my W-9, so I sent them a W-9.

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Q. And this is a very recent communication?

A. Yes.

Q. All right. Any other documents you brought in the room?

A. I have a list of my depositions for the last five years.

Q. And that consists of six cases; is that right?

A. Yes.

Q. How many depositions have you given in your lifetime, sir?

A. Maybe eight. A couple more in addition to these.

Q. All right. Do you continue to practice medicine, sir?

A. I do clinical shifts in local jails occasionally, maybe once every three to six months when I'm asked to do so by the -- to help out.

Q. And what jail is that?

A. When I do clinical shifts they are at the Bonneville County Jail in Idaho Falls, the Jefferson County Jail, and the Madison County Jail.

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Q. And when you are working there, are you working for a private company, or are you working for the government entities?
A. When I do those shifts, I'm working for Ivy Medical.
Q. And do you have an ownership interest in Ivy Medical?
A. No.
Q. And is that Ivy like the plant?
A. Yes.
Q. You're a fellow in the American College of Correctional Physicians --
A. Yes.
Q. -- correct?
A. Yes.
Q. And what does it require to become a fellow in the American College of Correctional Physicians?
A. One has to be a member of the college for four years, have been active participant in college activities such as committees, board, education, and have board certification in some other specialty.
Q. Do you know how many fellows there are in the American College of Correctional

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Physicians?
A. Not exactly. I believe there are about twenty-five or thirty.
Q. And does it require actual experience in the practice of correctional medicine?
A. Yes. I didn't mention that, but it does.
Q. How much experience?
A. Primary -- a lot. I would have to look at the exact -- I think it's termed significant in the fellowship criteria.
Q. Do you agree that the practice of correctional medicine presents unique challenges in terms of the patient population when considered in comparison to community practice?
A. Yes.
Q. And do you agree that the practice of correctional medicine presents unique challenges in terms of the patient population, in comparison to the outside community practice in terms of the population's mental health concerns?
MR. WEIL: Object to form.
THE COURT REPORTER: Excuse me, what was that?
MR. WEIL: Objection to form.

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Can you hear me okay?
THE COURT REPORTER: Not really. You're quiet.
MR. WEIL: Okay.
THE COURT REPORTER: Still quiet.
MR. WEIL: How about this?
THE COURT REPORTER: Still quiet.
MR. WEIL: I'll make sure I speak up.
THE COURT REPORTER: Thank you.
THE WITNESS: Would you repeat the question, please.
Q. (BY MR. KNOTT:) It's all right. I'm going to move on.
Can you tell me how you spend your professional time currently?
A. Most of the time I spend currently is working as the president of the American College of Correctional Physicians. I also do some expert legal consulting on a few cases, this being one of them.
Q. So approximately how many hours a week are you devoting to professional activities?
A. Somewhere in the neighborhood of ten to twenty.
Q. And how long has it been since you had a

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regular scheduled clinical practice?
A. Two-and-a-half years.
Q. And how old are you, sir?
A. I am sixty-eight.
Q. And of the ten to twenty hours that you spend currently in professional activities, what percentage of that is devoted to legal -- review of legal cases like this one?
MR. WEIL: Object to form.
Go ahead.
THE WITNESS: Half, approximately.
Q. (BY MR. KNOTT:) And is the other half devoted to your work with the American College of Correctional Physicians?
A. Yes.
Q. Do you do business either of those activities through a separate entity, business entity, of your own?
A. Yes. I have a business entity called TFS Correctional Consultants.
Q. And what does that TFS stand for?
A. Two Flying Swans.
Q. And so the work you're doing is billed through TFS Corporation; is that correct?
A. Yes.

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Q. And is the activity of TFS Corporation exclusively medical/legal consulting?
A. Yes.
Q. And other than medical/legal consulting and the shifts that you handle on an irregular basis for Ivy, do you have any other sources of professional income currently?
A. I published a book, and I get a little bit of money from sales of the book.
Q. And how many copies of your book have you sold?
A. Approximately one thousand.
Q. It's published directly to Kindle; is that correct?
A. Well, it's directly published both to Kindle and hard -- hard paperback copy.
Q. Okay. So the publisher is Amazon Kindle direct publishing, and it is available in a hard back?
A. Well, paperback, yes.
Q. I'm sorry. Paperback?
A. Yes.
Q. Yes?
A. Yes.
Q. You're -- what is the activity you

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perform for the American Medical Association Guides Panel? What is that?
A. Well, I've retired from that. That's another change in my resume, I guess. But the guides panel published the AMA Disability Guides, Guides to Disability, and the panel met monthly to discuss changes in the guides, and I was --
Q. Guides being some kind of publication?
A. Pardon?
Q. Guides being some type of publication?
A. Yes. There are several publications; but, basically, they have to do with guides to disability determinations, how to do a disability determination.
Q. Was that, at some point in your career, a significant part of your professional activities?
A. No.
Q. The -- your CV lists the Editorial Board of Med Page today.
Is that still active?
A. Yes. I believe I'm still on the editorial board, but it requires very little work.
Q. You're not sure?
A. No. I'm on the editorial board. It

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just requires very little work.
Q. And is Med Page today devoted exclusively to correctional health care?
A. No.
Q. Is your participation focus on correctional health care?
A. Yes.
Q. You have a personal blog at jailmedicine.com; is that correct?
A. I had, in the past, that blog. It no longer exists.
Q. It's no longer active?
A. Correct.
Q. And that when I tried to visit that domain, it was not available. Is that -- is that -- was your domain taken down?
A. Yes.
Q. And you published two hundred forty articles on jailmedicine.com?
A. Approximately, yes.
Q. Is there a reason why you no longer hold the domain?
A. When I retired two and a half years ago, I decided to retire from writing the blog. So I gave the blog to the -- and the domain to the

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American College of Correctional Physicians. They published maybe three or four articles, and then they basically let it die, and didn't pay the bills. And I considered trying to resurrect it, but I decided not to.
Q. Do you have access to the two hundred and forty articles that you published?
A. No. I have access to about one hundred of them.
Q. Do you know if you've ever written a blog post or article or a book chapter or any other form of writing on diagnosis of chest pain in a correctional setting?
A. Yes.
Q. And where did you address that?
A. I've addressed that in lectures, and I don't know if I've written a blog post or an article in a book about it. I can't remember off the top of my head whether I have.
Q. What lectures come to mind that you addressed diagnosis of chest pain in a correctional setting?
A. I believe I gave a lecture at the National Commission on Correctional Health Care. I don't know, ten, fifteen, years ago.

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Q. Do you believe the standard of care for dealing with chest pain in a correctional sitting has changed over the last ten to fifteen years?
A. No, I don't.
Q. You were the CEO of an entity called Badger Correctional Medicine, 1997 to 2021.
What was the nature of that business?
A. It was a company that provided medical care to incarcerated people in jails and juvenile centers in Idaho.
Q. I'm sorry, I missed the end of that, and that's my own fault because I was shuffling the paper.
A. It was a company that provided medical care to jails and juvenile centers in Idaho.
Q. And at its peak, can you tell me how many employees Badger Correctional Medicine had?
A. At its peak, maybe fifty.
Q. And did you employ nurses?
A. Yes.
Q. R.N.s?
A. Yes.
Q. LPNs?
A. Yes.
Q. Nurse practitioners?

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A. Yes.
Q. Physician assistants?
A. Yes.
Q. Physicians other than yourself?
A. No.
Q. And at its peak, how many contracts did Badger Correctional Medicine hold at a single time?
A. Seventeen.
Q. And that when was that, sir, if you remember?
A. Approximately fifteen years ago.
Q. So at that time were you the only physician covering seventeen facilities?
A. Yes.
Q. All right. And were there weeks when you as a physician did not visit those facilities, each of those facilities?
A. Yes.
Q. Can you tell me the largest number of beds at a facility where Badger Correctional provided the services?
A. Five hundred.
Q. And what county was that, sir?
A. Bonneville County.

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Q. And can you tell me how many beds were in the smallest facility that you held the contract for?
A. Ten.
Q. And what county was that, sir?
A. Fremont County.
Q. Can you list for me, as best you are able, the counties where Badger Correctional Medicine held a contract to provide health care services in the jail?
A. Okay. So not juvenile centers, I'm hearing you say.
Q. True.
A. Okay. Jails. Fremont County, Madison County, Jefferson County, Bonneville County, Bingham County, Jerome County, Elmore County, Owyhee County, Gem County, Letah County, and Nez Perce County.
Q. And did you contract with other entities in order to provide services in jails on behalf of Badger Correctional?
A. I don't understand the question.
Q. Did you employ another service to help you with, say, human resources or billing?
A. No.
Q. Did you perform the orientations of new

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employees yourself, sir?
A. I myself did the orientation for all of the practitioners and mental health professionals.
Q. And did you have an agenda for what you would cover?
A. Well, a check sheet, but most of it was them observing me in a clinic, and then me observing them in a clinic making sure that they were familiar with the policies and procedures and that they knew all the -- everything that they were supposed to do as part of their job.
Q. Did you provide them any training on aspects of the jail population that might be unique to the jail practice in medicine as opposed to the practice of medicine outside?
A. Yes.
Q. And what did you provide them in that regard?
A. One, jail patient -- you cannot fire jail patients, and jail patients can't fire you.
So I taught them techniques of what I call verbal Jujitsu which is how to defuse confrontations and maintain a physician/patient relationship.
Two, I taught them that you have to be

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fair. Outside medicine is not fair, but in a jail you have to be fair.

Three, I taught them that patients in a jail were -- often had not had medical care before they came to jail, and so especially at the beginning of their incarceration, they needed -- many of them needed extra attention.

I taught them that -- that they needed to be careful of the disease processes that were most likely to result in patient deaths such as suicide, withdrawal, diabetic problems, chest pain.

I taught them that -- I taught them how to -- what was expected of them when they got calls from nurses, and how and when to call me.

I taught them how to interact with security staff deputies.

That's probably not all of it.

Q. When you say you taught them how to interact with you, it's an acceptable process in correctional medicine for a nurse to do an interview and assessment of a patient and for the doctor to give orders based on the information relayed by the nurse; is that true?

MR. WEIL: Object to form.

Go ahead and answer.

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THE WITNESS: Yes. That is true, just as it is in outside medicine.

Q. (BY MR. KNOTT:) And are you aware of the facilities other than Monroe County jail where the correctional officers are engaged in the process of gathering information from the inmate in an organized way so that they can report it to the on-call physician in circumstances there's not a nurse or a doctor in the facility?

A. No. That was something new to me that I had not encountered before.

Q. Did you work for Badger Correctional -- did you work at facilities that did not staff nursing 24/7?

A. Yes.

Q. And they didn't have practitioners available 24/7?

A. They always had practitioners available 24/7 on an on-call basis. They had nurses and practitioners that were available to all facilities 24/7 on a call-back basis.

Q. So in a facility in which there's not a nurse available, say in the evening hours, and a patient reports a new symptom, say, a severe dizziness, how is the doctor alerted in your

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practice?

A. Would you rephrase that? I think I hear you asking how would that be handled, and would that have been handled in one of my jails.

Is that correct?

Q. That's correct.

What I'm trying to get at is if the inmate reports a symptom and there's not a nurse available, how is that new event relayed to the physician?

A. Well, the first call usually would be from the security staff to the nurse who would then go to the jail and do a patient assessment. And then the nurse would always, there was no option not to, would always call the practitioner on call, and then a decision would be made.

A patient could be sent to the ER at any time before the nurse came or when the nurse got there, but once the nurse did the assessment and called the practitioner, a decision would be made whether to send the patient to the ER.

Or the practitioner goes into the jail and sees the patient personally, or this can wait until reassessment tomorrow, a secondary assessment tomorrow by the nurse, and the practitioner would

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always see that patient, always, always, but at the latest would be at the next scheduled clinic.

Q. So in your practice, there's never direct communication between the security staff and you the physician?

A. They could call me, but would not give them orders over the phone. I would just say: You have a choice to make whether to send the patient to the ER or to wait for the nurse to get there, which is usually about twenty minutes, and it's a call you have to make.

I mean, that's the training I would give them. I gave officers training, too.

Q. And the training was that they should contact the nurse first with any report of new symptoms?

A. They could call me -- they could call the practitioner as well, and they could call me.

And I did receive calls from jail security staff over the years, and most of the time if they were so concerned about a patient that they called -- that they bypassed the nurse, bypassed the petitioner, and called me directly, I would say send them to an ER.

Q. But the practice and protocol that you

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trained on, was that the security staff would contact the nurse, and the nurse would physically report to the jail and do an assessment before any decisions were made?

A. In most cases, yes.

Q. And you referenced you trained your staff on the art of verbal Jujitsu in order to interact with inmates.

Did I get that correct?

A. Well, it's not just inmates. This is a practice that actually I learned in an emergency department. If a patient, as some patients do in any practice, gets aggressive, then you need to know how to deal with that in an effective way. An ineffective way is to yell back; for example, don't do that. So, yes, I taught that.

Q. And your initial response said that you taught them that it's a no-fire situation. They can't fire you and you can't fire them.

And then I think you said so we teach them the art of verbal Jujitsu.

Did I have that correct?

A. Yes.

Q. And does the manner in which you are required to interact with a patient vary for an

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inmate in a jail versus a patient in the ER?

A. I didn't get that question. Would you restate it, please.

Q. Actually, could DiAnn read it back?

THE COURT REPORTER: Yes.

Question, And does the manner in which you are required to interact with a patient vary for an inmate in a jail versus a patient in the ER?

THE WITNESS: No. The proper way to interact with any patient in any practice setting should be about the same.

Q. (BY MR. KNOTT:) And you said that you trained your employees that they need to be fair in that, I think you said, health care outside is not fair but it needs to be fair inside?

A. Yes.

Q. Did I understand that correctly?

A. Yes.

Q. And what did you mean by that, sir?

A. Well, as to give one example, some patients on the outside don't have insurance, and they have lesser access to medical care than people who are well insured.

In a jail, everybody has the same access to medical care, and you need to do the same thing

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for all patients in similar situations.

Q. Do you agree with me that a proper orientation for health staff to work in a correctional facility, should, among other things, focus on the similarities and differences between providing health care in the community and in a correctional setting?

MR. WEIL: Objection.

Go ahead and answer.

THE WITNESS: There are differences practicing medicine in a correctional facility versus the outside, important differences, and those do need to be addressed in orientation.

Q. (BY MR. KNOTT:) Did you say the important differences need to be addressed in orientation?

A. I said there are differences. There are important differences that do need to be addressed in orientation.

Q. So do you agree with me that it is appropriate for an orientation for health care staff to focus on the similarities and differences between providing health care in the community and in a correctional setting?

MR. WEIL: Object to form.

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Go ahead and answer.

THE WITNESS: Well, that's a general question, but yes. Practitioners in a jail need to know what the differences are and why they're important.

Q. (BY MR. KNOTT:) And one of the things you train on are the disease processes that might be likely to lead to death in a jail, correct?

A. Yes.

Q. And did you review any training by ACH for its employees on that topic?

A. Yes.

Q. And was that training on that topic appropriate?

A. So training for the -- that was provided about chest pain, and other topics that are reviewed was, for the most part, appropriate.

Q. So you've included in your report a single slide from a presentation called Introduction to Correctional Health Care, just so we can exclude discussion of the other training, is it fair to say you have no criticism of the training provided other than that particular topic?

A. Yes.

Q. And your concern about that topic is it

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creates -- well, strike -- strike that.
Your concern about that topic is based on the four or five slides that Susan Bentley included in her report?
MR. WEIL: Object to the form.
THE WITNESS: Well, it's based on my own review of that. I reviewed the slides, and I've listened to the lecture two or three times. And I -- as I said in my report, I think that the training is wrong, and that that will lead people, whether subtly or overtly, to practice bad medicine.
Q. (BY MR. KNOTT:) And is there a published standard on the training of that topic that you can cite to by which you judged that training that you reviewed?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: So I'm not aware of any published training materials. My opinions about that are based on my own experience. Yes, based on my own experience.
I'm not aware of any published -- broadly published training materials for correctional medicine.

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Q. (BY MR. KNOTT:) Any other source in medical literature and correctional literature, in presentations that you've seen, or books that you can cite as the source of the standard by which you judge that introduction to correctional health care training?
A. Yes. Not that I can cite specifically, but yes. I've been to many lectures, and seminars, where this topic has been discussed, and those -- those also figured into my opinion about this training.
Q. Those topics have been discussed meaning what?
A. Meaning I've heard other people lecture about this topic about whether incarcerated people are different in how they frame complaints than people on the outside, and should they be approached differently by medical people as far as judging the veracity of their complaints. I have heard lectures about that.
Q. And when did you hear lectures about that?
A. I don't know. I've been going to lectures at the National Commission on Correctional Health Care, the -- my organization, the ACCP, the American Correctional Association, Idaho Sheriffs Association, other -- many places.
This topic has been discussed, I can't give you an exact time and date, but it's been discussed. It's a topic of discussion.
Q. And so when you say that training is wrong, you're saying it's not consistent with your experience.
Is that fair?
A. It is not.
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: Well, amongst other things, I think it is not consistent with my experience and the experience of other people with whom I've -- that I've listed to and discussed the topic with.
Q. (BY MR. KNOTT:) Have you yourself presented orientation for health care staff for any entities other than Badger Correctional?
A. I taught Introduction to Correctional Medicine at the Idaho POST Academy, the Police Officer Standards Training, for all new hires for detention for jail positions, for a couple of years. Of course, that's not correctional staff.

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I've taught some training for my other job, which was when I was the chief medical officer for Centurion. I did some training there.
I did some -- I have done some training for other entities that did include -- at conferences that did include correctional staff.
I've never --
Q. Have you --
A. I'm sorry.
Q. I'm sorry, did I interrupt you?
A. No. I think I'm done.
Q. When you taught Introduction to Correctional Health Care for Badger Correctional, did you use a recorded video?
A. No.
Q. Did you reference any written materials as your source?
A. No, other than that they needed to be familiar with the policies and the -- the written policies and procedures of Badger, and also the -- they needed to be -- understand the guidelines of the National Commission on Correctional Health Care.
Q. If an entity in correctional health care complies with National Commission on Correctional

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Health Care standards, you agree they are generally within the standard of care?
MR. WEIL: Object to form.
You can answer.
THE WITNESS: I think it is a good thing to comply with the National Commission on Health Care Standards, but just being accredited by the National Commission of Correctional Health Care does not mean that every single bit of health care that is done within that facility meets the standard of care.
Q. (BY MR. KNOTT:) Did you reference the National Committee on Correctional Health Care's standard on orientation of health care staff when assessing the adequacy of the training by Advance Correctional?
A. No.
Q. Do you believe generally that the privatization of health care in jails leads to diminished quality of care?
A. No. Not necessarily.
Q. Did you, in marketing yourself to counties, suggest to the counties that you could provide better services and save them money?
A. Well, my -- I never -- none of the

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contracts that I got, the seventeen contracts that I got, were a result of a response to an RFP. They were all -- they were all direct, you know, can you provide medical care to our county and how much would it cost, and that sort of thing.
But I didn't -- I didn't respond to RFPs, so I didn't actually market in the way that you're saying.
Q. Okay. So taking the marketing out of it, were you able to provide adequate health care while saving the government entity money?
A. Yes. I did save some of -- some of my contracts quite a bit of money.
Q. And do you believe you did that by cutting and diminishing the quality of care?
A. No. I did that by increasing the quality of care.
Q. While cutting the cost?
MR. WEIL: Object to form.
THE WITNESS: Well, good medicine is cost effective. Bad medicine is expensive, so by eliminating bad medicine, you save money overall.
Q. (BY MR. KNOTT:) So you admit that private health care entities can save a government entity money while at the same time improving the

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quality of care. That's possible.
A. That is possible.
MR. WEIL: Object to form.
Q. (BY MR. KNOTT:) When you took a contract for a county correctional facility for Badger Correctional, did the county specify the staffing, or did you?
A. Both. I recommended staffing and county's -- county commissioners and sheriffs sometimes said no, we don't think it should be staffed that much. So sometimes there was a compromise on staffing.
Q. Were there times when the commissioners and administrators did not want to adopt your recommendation for staffing?
A. Yes.
Q. And did you proceed forward with some sort of compromise that allowed you to work at that facility?
A. Yes.
Q. Badger Correctional remained in business in 2019 through 2021?
A. Yes. I believe we ceased operations in 2021, so from 2019 to 2021, yes.
Q. Can you tell me how many contracts you

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had for county jails in 2019?
A. One, two, three, four, five -- I think five.
Q. You counted up to five there, Doctor?
A. I believe five.
Q. Okay. And did that increase or decrease in 2020?
A. I'm not sure what you're asking.
Q. Did the number of contracts you had for county jails increase or decrease in 2020?
A. Well, the number -- I didn't add any contracts for about the last ten years maybe, so they all decreased. So it was always a decrease. Why there was a decrease that happened in 2020, I'm not sure.
Q. And did you carry professional liability insurance for your entity?
A. Did I have professional liability insurance?
Q. Yes.
A. Yes.
Q. And how did you determine how much professional liability insurance you would carry?
A. In conversation with my agent.
Q. Did the government entities ever specify

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the amount of professional liability insurance they required for you to have the contract?

A. Some of them did, but most of the time they required less than what I -- what I had.

Q. And when you say that some of them required less than what you had, can you tell me what -- how much professional liability insurance you carried in 2020? I'm sorry, 2019.

A. 2019. I'm not exactly sure how much I carried in 2019. It might have been one -- one million, three million, but I don't know. It might have gone up, so I'm not sure exactly. But that's probably what it was.

Q. So you understood that to be insurance coverage against claims by patients, including inmates, up to one million per single claim, and three million aggregate for a year?

A. Yeah. We're talking, just to make sure we're talking about the same thing, I'm talking about malpractice coverage.

Q. Correct.

A. Yes.

Q. That's what I mean when I say professional liability.

A. I believe that that is correct.

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Q. And did your professional liability insurance cover you against claims for violation of civil rights that might be asserted in federal court?

A. Well, I assume so because I was fully covered, according to my agents.

Q. Do you know who your insurer was?

A. UMIA, Utah Medical Insurance -- it changed names, but I believe the last entity -- it was the same insurance all the time, but it changed names. The last one was UMIA.

Q. And in your opinion as the administrator of a jail correctional health entity, did you believe you were adequately insured?

A. Yes.

Q. Did you ever seek to get additional liability coverage?

A. No.

Q. Did you consciously choose to obtain limited liability insurance in order to shift the cost of correctional health care off the government and onto you?

A. I don't understand.

MR. WEIL: Object to form.

THE WITNESS: I don't understand that question.

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Q. (BY MR. KNOTT:) Did you limit your liability coverage to a million dollars so that you could make yourself judgment proof?

MR. WEIL: Object to form.

THE WITNESS: No.

Q. (BY MR. KNOTT:) At the peak of your work for Badger Correctional, do you know how many patient interactions your staff had daily?

A. Off the top of my head, no.

Q. Was that a statistic that was monitored from year to year?

A. It was monitored in each facility. I don't know if we ever added them all up as one -- as a group.

Q. And was it monitored in each facility as part of the CQI process?

A. Well, statistics aren't CQI, so it was something that we did, but it wasn't labeled as part of the CQI. But it was something that we did. We kept statistic.

Q. And did you discuss those statistics with the jail administration?

A. Yes.

Q. Doctor, were you ever sued personally in any context?

A. So one of my employees sued -- I don't know if I was sued personally, but one of my employees sued Badger Medical, and I guess me, personally, alleging that we violated her Americans with Disability Association rights.

Q. Were you ever -- you or your entity ever sued by an inmate over health care issues?

A. In Idaho, before you -- before it becomes a formal malpractice suit, claims -- malpractice claims have to go to an arbitration board. It's not an arbitration board, but they have to be heard by a board from the Board of Medicine first.

And I had a couple that went to that and were found to be -- have no merit. The patient could still file a malpractice suit, but none of them did. So no, I never had a malpractice claim that actually made it as far as a formal malpractice claim.

Q. And when you say that there were a couple of claims filed about the Board of Medicine, is that two?

A. I don't remember. Two or three.

Q. And did an inmate ever file a lawsuit or

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a claim of negligence against any employee of Badger Correctional?

A. Not that I remember.

Q. Have you ever settled a claim involving an inmate?

A. No.

Q. Have you ever admitted to an inmate that you made a mistake?

A. Yes.

Q. Have you ever taken discipline against an inmate or against an employee for what you thought was mistaken judgment?

A. Yes.

Q. And with respect to your disclosure cases, I apologize, I think there's six disclosed, and you think you've given eight depositions in your career.

A. Yeah. The ones I've disclosed are the ones in the last five years, and I've done a couple before that. I could find out the exact number, but I'm not sure. I think it's two or three.

Q. And did you give a deposition in any context other than as a retained expert witness?

A. Yes. I've given a deposition in a divorce case, and I've given a deposition in the ADA

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case that I referenced earlier.

Q. Were those included in your mental count of --

A. No.

Q. -- eight or nine?

A. No.

Q. So you think there may be eight or nine cases that you testified as a retained expert witness?

A. Yes.

Q. And have you ever testified in court, sir?

A. Once.

Q. Where was that?

A. In Pennsylvania.

Q. Can you tell me the number of cases you have reviewed in your career?

A. Not exactly.

MR. WEIL: Object to form.

THE WITNESS: Approximately twenty-five or thirty.

Q. (BY MR. KNOTT:) And how did you first enter into the business of being an expert witness?

MR. WEIL: Object to form.

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Go ahead and answer.

THE WITNESS: I was contacted by and asked to do it.

Q. (BY MR. KNOTT:) And do you know the percentage of cases that you've reviewed where you were reviewing it on behalf of the plaintiff's side or the inmate's side versus the defense side, the health care provider's side?

A. Not exactly, but I'm going to estimate ten to fifteen percent defense and the rest plaintiffs.

Q. Are your services as a litigation consultant advertised anywhere, sir?

A. No.

Q. Or listed on any list of expert witnesses, if you know?

A. No. Not that I know of.

Q. Have you reviewed other cases for the Loevy & Loevy firm?

A. Yes.

Q. When did you first review a case for the Loevy and Loevy firm?

A. Four years ago, five years ago.

Q. And how many cases, other than this one, have you reviewed for the Loevy firm?

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A. One.

Q. And where does that case arise out of? Where does it arise out of?

A. I don't -- you know what? I don't know the answer to that. In my mind it was the Bosche case. I don't know where it arose out of.

Q. You kind of leaned back there, sir, and I lost you. I couldn't hear you.

A. In my mind it's the Bosche case. I don't remember where it arose from.

Q. Did you issue a written report in that case?

A. Yes.

Q. And can you tell me what the medical issue was in that case?

A. The medical issue was that the company that was providing medical care had a corporate-wide push to reduce emergency room referrals, corporate-wide, so the practitioners were told stop sending so many people to the emergency department.

Q. All right. And what was that company?

A. Was it Wexford? I think it was Wexford.

Q. Did you say Wexford?

A. I believe it was Wexford.

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Q. And what was the evidence of their corporate-wide push to reduce trips to the ER?
MR. WEIL: Object to the form.
Go ahead and answer.
THE WITNESS: It wasn't a secret. They published it. It was something that they -- that they put out as a corporate-wide push. This is something that we're going to try to do is reduce emergency department referrals.
Q. (BY MR. KNOTT:) And that that was to save costs?
MR. WEIL: Object to form.
Go ahead.
THE WITNESS: My opinion was yes, that was to save costs.
Q. (BY MR. KNOTT:) And, sir, you have not seen in this case, the Boyer case, any evidence of a corporate-wide push to reduce trips to the emergency room, have you?
MR. WEIL: Object to form. Go ahead and answer.
THE WITNESS: I have not seen an overt program to reduce emergency room department referrals.
Q. (BY MR. KNOTT:) Have you testified in

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cases involving diagnosis of chest pain?
A. I can't think of another case involving chest pain that I've been an expert witness on.
Q. So do you have any explanation for why ten to fifteen percent of the cases you review are for the defense and the majority are for the plaintiff?
A. Because I mostly get contacted by plaintiffs' attorneys.
Q. Have you ever had your qualifications to testify in court challenged?
A. No.
MR. WEIL: Object to form.
MR. KNOTT: We've been at it for a little bit here, and I could use a break. If we could take a few minutes, I think it would be an appropriate time to do that.
MR. WEIL: When do you want to come back, Doug?
MR. KNOTT: Realistically, five minutes to 1:00.
MR. WEIL: Five to 1:00? Okay.
(A brief recess was had.)
MR. KNOTT: Back on the record.
Q. (BY MR. KNOTT:) Doctor, if we

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weren't -- Doctor, I learned during the break, but didn't get a chance to look at, an e-mail from Mr. Weil sending us what I believe are the materials you reviewed.
Did you create notes or some other type of file for the review of the inmate cases?
A. For the preparation of my report, I did drafts.
Q. So my question is: When you reviewed the records, did you create any type of work product or synthesis or abstract or chronology or anything other than work on a draft report?
A. I created -- I did snips, which is if I saw something in a record that I wanted to include in my draft, I snipped it as a -- basically a picture, and then I organized those and used those to create the draft.
Q. And was that in a separate document other than your draft?
A. Well --
MR. WEIL: Object to form.
THE WITNESS: I used them to create the draft, and then -- so, no. There's no separate document.
Q. (BY MR. KNOTT:) So you took snippets,

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screen snaps, from the PDFs and put them in your draft report directly.
Is that what you're saying?
A. No. I -- well, I didn't paste them in, but I used them to write into my -- because they're more convenient to write from, so I used them to write from.
Q. So I guess bottom line, on your review of these hundreds of thousands of pages of material, you didn't create any notes of your own other than your report?
A. Correct.
Q. And were the materials provided to you in a format that was -- that directed you to certain pages?
MR. WEIL: Object to form. Go ahead and answer.
THE WITNESS: I was provided with material that said look at particular cases. I don't remember that I was given actual pages to look at.
Q. (BY MR. KNOTT:) And is that correspondence that you have received from Weil's firm, Attorney Weil's firm?
MR. WEIL: So I think we're treading

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into a privileged area here. I'm going to object.
And if I can have a minute with the Doctor, we can resolve the privilege. Otherwise I'm going to instruct him not to answer as the question is currently posed.
MR. KNOTT: Completely inappropriate.
MR. WEIL: Well, I'm instructing him -- I'm going to let you take your deposition. This is similar to a -- I want to just preserve the privilege while letting you take your deposition on discovery materials. The question that you're asking covers privileged and nonprivileged communications, so I want to --
MR. KNOTT: So you're directing him not to answer that question.
MR. WEIL: As it's phrased, yes.
Again, I think we can clear it up pretty easily, but as a straight, yes, I would direct him not to answer.
Q. (BY MR. KNOTT:) Doctor, did I hear you correctly that you received from Attorney Weil's office correspondence saying you should look at particular cases?
MR. WEIL: Object to form and instruct the witness not to answer because of privilege.

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Again, we can resolve this by properly narrowing the question or have a side bar with the doctor. As phrased, I instruct him not to answer.
MR. KNOTT: Mr. Weil, can you tell me what I received after the deposition started? Because I'm not in a position to study it now.
MR. WEIL: So I believe what you're referring to is what I sent before the deposition began, which are the series of summaries and a -- of different cases, and then a table of a bunch of cases for Monroe County.
I don't have a problem asking Dr. Keller about that. The privilege would be any discussions beyond the materials we provided him where we're talking about -- you know, talking about various cases or the different medical situations that are in the record. So that's the distinction I'm drawing.
MR. KNOTT: I don't want to take the time to delve into the e-mail that you sent me, so could you tell me that again? You sent summaries?
MR. WEIL: There is an e-mail that we sent before the deposition that contains various summaries of different cases of medical care outside of Monroe County.

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There is also a table that I would say contains more truncated summaries of care within Monroe County, and those were provided to Dr. Keller in the course of preparing this report.
Q. (BY MR. KNOTT:) Is that your understanding as well, Dr. Keller?
A. Yes.
Q. And did you add to the summaries or the truncated summaries that Mr. Weil described, any of your own notes?
MR. WEIL: Object to form. Go ahead and answer.
THE WITNESS: Well, my -- what I've -- what I have written in my report is based on my own review of the charts.
Q. (BY MR. KNOTT:) I'm really looking for your notetaking of any kind independent of the report. And trying to see -- it just strikes me as a difficult task, Doctor, to review hundreds of thousands of pages without taking notes.
MR. WEIL: Object to form. Asked and answered.
THE WITNESS: I used snips. So in the past, yeah, I took -- I would take handwritten notes or whatever, but snips works quite a bit better

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because for one thing in the snip I can -- it includes exactly where it is; whereas, if I take a handwritten note, in the past, I've forgotten where it came from, and I can't find it again. So snips works better, and that's how I do it.
Q. And a snip is the application within Windows that allows you to capture a section of the screen?
A. Yes.
Q. And does your -- does a document with the snips that you selected exist anywhere?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: Well, early -- early drafts of my report didn't include the snips themselves, but they included the verbiage that I transcribed from the snips.
Q. (BY MR. KNOTT:) And did you highlight or put Post-Its or anything like that on any of the PDFs that you reviewed?
A. Probably. As a matter of fact, yes, I did.
Q. And what did you -- what kind of note did you take? Highlight? It was a double question. I asked if you highlighted or took notes.

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Can you tell me which of those two you did?
A. I highlighted.
Q. And did you save your highlighting?
A. Probably.
Q. And is that in a -- on PDFs maintained by you?
A. Yes.
MR. KNOTT: And were those provided to me, Mr. Weil?
MR. WEIL: I don't believe they were. Unless Dr. Keller sent them over, I don't believe they were.
Q. (BY MR. KNOTT:) Did the -- your report references minutes of the Davis or Davis County Commission in 2004. Does that have any bearing on your opinions in the matter?
A. Do you mean where I said it's -- I reviewed it, it's in the documents that I reviewed?
Q. Yes.
A. No, it doesn't.
Q. So I understand from review of your report that your opinions endorse and apply Dr. Bentley's opinions in the context of correctional medicine.

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Is that a fair characterization?
A. Could you rephrase the question? I guess I'm not exactly understanding what you're saying.
Q. (BY MR. KNOTT:) Yeah. I'm trying to understand. Well, your report covers a discussion of other inmates, and setting that aside for a second, your report comments on the care provided to Christine Boyer.
True?
A. So Mr. Weil did not ask me to directly address the care given to Christine Boyer, so I don't have a separate section in my report directly dealing with her case.
I endorse Dr. Bentley's summary of that case. There's nothing that she said that I disagree with.
Q. And I just want to focus our discussion. Your opinions with respect to the care provided to Ms. Boyer follow the contours exactly of what Dr. Bentley has testified to, correct?
A. Yes.
Q. Put in her report more fairly.
You haven't seen Dr. Bentley's testimony, have you?

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A. You mean her deposition? No, I have not.
Q. And you haven't talked to Dr. Bentley, have you?
A. No.
Q. And I guess I'm kind of having a hard time dealing with this conceptually, but if I look at your report at page 2, carrying over to 3, the medical standard of care in the case of Christine Boyer, is there any opinion you intend to offer at the time of trial that's set forth in that section other than you agree with the opinion of Dr. Bentley?
MR. WEIL: Object to form.
THE WITNESS: So if you're referring to the -- the sentence says: The medical standard of care in the jail is no different than the medical -- excuse me, standard of care in the community, that incarcerated patients are entitled to the same level of medical care as unincarcerated patients, I stand by that.
I believe that's what Dr. Bentley said as well, but that's -- independently that's my opinion as well.
Q. So my question was actually about that

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section from the bolded statement, the medical standard of care on page 2 down to training provided by ACAH.
And what I'm trying to get at is: You were not asked to independently review the facts and circumstances of Ms. Boyer's care, fair?
A. Not exactly. I was -- I reviewed them. I was not asked to write a report about them. But I did review the circumstances revolving the care given to Ms. Boyer.
And I believe that Dr. Bentley summarized it well, and I agree with everything that -- with all of her conclusions.
Q. You agree you're qualified to speak to the care of a registered nurse?
A. I am qualified to speak -- well, in a word, yes.
Q. Okay. And your report includes no discussion of the particular interactions of the staff and Ms. Boyer on December 21 or 22, correct?
A. No.
Q. Not correct or correct?
A. No. My report does not include a discussion of the care given to Ms. Boyer. I was not asked to do that. But I do agree with

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Dr. Bentley's summary. There is nothing in her report that I disagree with, with regard to the care of Christine Boyer.

Q. My understanding is that you're not offering opinions on the standard of care of the correctional staff, true?

A. Other than to say I agree with Dr. Bentley's assessment, I didn't directly address that in my own report.

Q. Do you have in mind at this time any opinions that Ms. Bentley rendered with regard to the corrections staff?

A. I guess I don't understand the question.

Q. You're saying that you don't have any opinions regarding the correctional staff other than to agree with those stated by Dr. Bentley.

And my question is whether you have in mind here today any particular opinions concerning the correctional staff.

A. Well, I didn't address this in my report other than to say I agreed with Dr. Bentley's assessment.

Q. Okay. I'll leave that there.

In your report, you referred to the

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standard of care. Can you tell me what's meant by the phrase standard of care, as it's used in this report?

A. What I meant when I said the standard of care is basically the care that would occur in outside medical setting, and I also mean the -- what is commonly believed and taught in medical textbooks as being appropriate care for certain conditions.

Q. And when you're talking about the standard of care of a physician practicing correctional medicine, is there a textbook that you could cite for the standard of care?

MR. WEIL: Object to form.

Go ahead and answer.

THE WITNESS: Well, the medical textbooks are no different for correctional physicians as they are for noncorrectional physicians. There's not a different medical textbook for corrections as noncorrections. That's kind of the point as being a uniform standard.

Q. (BY MR. KNOTT:) So if I understand your prior answer, you define the standard of care as one care that would occur in an outside facility and care as it's taught in textbooks, if I remember that correctly?

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MR. WEIL: Object to form. Go ahead and answer.

THE WITNESS: That is an okay summary.

Q. (BY MR. KNOTT:) I'm sorry, I didn't hear that.

A. That is an okay summary.

Q. Okay summary?

A. I agree with that summary.

Q. Thank you.

Are you familiar with the Constitutional standards governing health care providers in a jail or prison setting?

A. Yes.

MR. WEIL: Object to form.

Go ahead and answer.

Q. (BY MR. KNOTT:) You've heard the term deliberate indifference under the 8th Amendment?

A. Yes.

Q. And you've heard the term objectively unreasonable under the 14th Amendment? Have you heard that phrase?

MR. WEIL: Object to form.

Go ahead and answer.

THE WITNESS: Yes.

Q. (BY MR. KNOTT:) Are you intending, when

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you refer to the standard of care in your report, to be referring to a constitutional standard?

MR. WEIL: Object to form.

Go ahead and answer.

THE WITNESS: No. I had no intention of addressing legal issues or constitutional issues. I am addressing medical issues.

Q. (BY MR. KNOTT:) Is a violation of the standard of care, as you phrase it, negligence?

MR. WEIL: Object to form.

Go ahead and answer.

THE WITNESS: It can be.

Q. (BY MR. KNOTT:) Do you agree that different practitioners can approach the same patient differently and still be within the standard of care?

MR. WEIL: Object to form.

You can answer.

THE WITNESS: That depends on the case they're approaching. There are some cases where if you do two different things, one can be right and one can be wrong.

There are other cases where, yes, you can -- two different practitioners can approach it different ways, and both be okay, but it depends on

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the case.
Q. (BY MR. KNOTT:) The standard of care for a primary care practitioner is different than the standard of care for a neurologist, isn't it?
MR. WEIL: Object to the form.
Go ahead and answer.
THE WITNESS: So I'm not sure exactly where you're going with that.
A neurologist is trained to do different things than a -- than a primary care physician. The expectation of a neurologist is based on his training.
So I'm -- I don't know exactly where that is going. A primary care physician is not trained to do neurosurgery, and so that is not what the standard is for them.
Q. What I was getting at is there's not a single standard of care for all classes of medical providers, is there?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: I'm not sure if I agree with that. There are -- people have different specialties and different areas of expertise, but the overall medical care that's provided to a

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patient, everybody has their role, and probably should stay in their lane, but the overall care is no different for one physician than -- I mean, the care depends on the patient. So what a primary care physician does would be different than what a specialty care physician does, but they both are in pursuit of the overall medical standard.
Q. (BY MR. KNOTT:) You, as a medical doctor and board certified emergency room physician, are not in the same licensing class as a nurse practitioner.
Agree?
A. Correct.
Q. Same with respect to a registered nurse.
A. Correct.
Q. And do you have any idea of the requirements to practice as a nurse practitioner in the state of Wisconsin?
A. Yes.
MR. WEIL: Object to form.
Go ahead.
Q. (BY MR. KNOTT:) And what do you know about that?
A. Well, that's a broad question. It's similar all over the country. There are some states

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that allow nurse practitioners to practice independently. I don't believe Wisconsin is one.
Q. Have you ever been -- have you ever been a collaborating physician for a nurse practitioner?
A. Yes.
Q. I want you to consider a hypothetical, Doctor.
A gentleman walks into a hospital emergency room and says: I want Tums, antacid.
Is the standard of care for the response to that the same in the emergency room as it is in a jail?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: Yes.
Q. (BY MR. KNOTT:) Doctor, if you assume that the standard of care, as defined by the courts in the state of Wisconsin, is what a reasonable provider in the same class of providers would do under the same or similar circumstances, if that's the definition of standard of care in Wisconsin, would you agree that you're not qualified to speak to the standard of care of a nurse practitioner?
A. No.

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MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: No.
Q. (BY MR. KNOTT:) You would not agree?
A. I would not agree.
Q. Because you know what a reasonable provider in the same class of providers would do under the same or similar circumstances?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: So it might be that what we're talking about is scope of practice. So going back to the neurosurgeon and the family practice doctor, I think that they're -- the standard of medical care is the same, but they have different scope of practices, so it would be inappropriate for the family doctor to try to do neurosurgery. That's beyond her scope of practice.
The scope of practice of nurse practitioners and physicians and a primary care physician differ a little bit, but for the most part, they overlap, like two circles that overlap in the middle. There's a little bit on either side.
But for the most part, they're both practicing primary care medicine, and it's the same

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for -- the expectations are the same for both.
Q. Doctor, when you contracted to provide health care services in jail, did your company bear the costs of medications that were prescribed?
A. In one contract, yes.
Q. And in other contracts no?
A. Correct.
Q. And did your practice differ based on whether you -- your company bore the costs of the medication?
A. No.
Q. And did your company bear the costs of sending inmates out for specialty care?
A. No.
Q. Or for emergency room visits?
A. No.
Q. Do you know whether Advanced Correctional Health Care, under their contract with Monroe County Jail, bore the costs of sending inmates to the emergency room?
A. I believe the answer to that is no. They do not bear the costs.
Q. And I understand that you are critical of the training that was provided by ACH as potentially fostering bias.

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I don't see in your report any opinion that you're critical of the training for encouraging providers to limit services in the interest of profit.
Did I read your report correctly?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: So you might need to restate that question, because I'm not sure exactly what I'm being asked here.
Q. (BY MR. KNOTT:) Maybe I'll try it a different way. I'm talking about training.
You did not see any evidence in the training that ACH was encouraging providers to limit the services they provide in the interest of profit, did you?
MR. WEIL: Object on form.
Go ahead and answer.
THE WITNESS: No, not in the training. I think Nurse Fennigkoh sent some e-mails that referenced -- referenced that, but I didn't quote that in my report.
Q. (BY MR. KNOTT:) Nurse Fennigkoh's concern was the cost to the inmate, wasn't it?
MR. WEIL: Object to the form.

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THE WITNESS: Not the way I read it, but I didn't put it in my report so -- and I don't remember reading that in her deposition, so I can't comment. I can't answer that.
Q. (BY MR. KNOTT:) And my understanding from reading this report is that there's no written policy by ACH that you think is deficient, true?
A. Well, whether it's written or not, I think the policy of allowing people to practice outside their scope of practice is wrong even if it's not written as such. The general practice is that that's what happens.
And the general practice is that practitioners are allowed to practice medicine over the phone without ever seeing the patient, and nurses are allowed to practice outside their scope of practice by making diagnoses and prescriptions of legacy drugs, which is outside their scope of practice.
All of that is tolerated, whether or not it's written.
Q. And the question was whether you're aware of any written policy that you believe is deficient.
So I understand from your answer you

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don't believe there's a written policy that's deficient.
A. No.
MR. WEIL: Object to form.
THE WITNESS: Not that I recall.
Q. (BY MR. KNOTT:) So of the cases that you reference in your report for the Monroe County Jail and other cases, those were cases that were selected for you by Mr. Weil's firm for you to review, true?
MR. WEIL: Object to form.
Go ahead and answer, if you know.
THE WITNESS: Well, they are all cases from the complaint, so in that sense they were chosen. I think every case --
Q. (BY MR. KNOTT:) And did you review -- I'm sorry, were you done?
A. I was going to say every case in my report out of Monroe County was in the original complaint. So in that case, in that way they were chosen because those are the cases that I focused on.
Q. And did you review medical records before the Fourth Amended Complaint was filed?
MR. WEIL: Object to form.

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Go ahead and answer.
THE WITNESS: I don't remember. I don't remember reviewing charts before I knew -- before I knew exactly which charts I was looking at.
Q. (BY MR. KNOTT:) Do you know who reviewed the charts in order to select the cases that were included in the amended complaints?
A. The exact person, no.
Q. You know that it was someone with Mr. Weil's firm, right?
A. Yes.
Q. And so you have not reviewed the medical records for any inmate that Mr. Weil has not selected for you to review, true?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: No.
Q. (BY MR. KNOTT:) So you understand that Mr. Weil has access to around thirteen hundred Monroe County inmate files?
A. Yes.
Q. And he's had access to those for more than a year. You know that, right?
A. I don't know when he originally obtained access to them.

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Q. And my understanding is you didn't review the county medical records and tell him which records are significant. You didn't review the thirteen hundred to determine which are significant, true?
A. True.
MR. WEIL: Object to form.
Q. (BY MR. KNOTT:) Do you know if eleven cases out of thirteen hundred cases is statistically significant, Doctor?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: No.
Q. (BY MR. KNOTT:) Do you agree that to offer -- agree as a scientist that to offer a valid opinion about the quality of ACH services at the Monroe County Jail, that you should look at a random selection of files rather than those selected by the plaintiff's firm?
A. I wasn't doing --
MR. WEIL: Object to form.
THE WITNESS: -- a scientific study. Instead, I was looking at the way that the contract was set up, and what I found is confirmation of things that originally came out of Christine Boyer's

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case, that is that correctional officers were functioning in the role of nurses and, in fact, were provided with a long list of -- a long -- a big group of files that they were supposed to use when communicating as in the form of nurses to practitioners, that practitioners were prescribing -- diagnosing and prescribing without seeing a patient based on phone interviews and never seeing the patient.
And that nurses were prescribing outside their scope of practice without ever escalating care to appropriate levels, and that patients were not -- were not being escalated to appropriate levels.
I think I saw enough cases to think that that is a robust statement, and I don't even know if ACH would disagree with that, that they do ask correctional officers to fill out forms and call in, and that practitioners then give orders back to them about giving drugs to inmates, et cetera, et cetera.
So I thought I had enough data from those eleven cases that there was no reason to go through thirteen hundred. I suspect if I did go through thirteen hundred, it wouldn't be that there were no correctional officers calling in about patients on the other thirteen hundred. I think

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they were.
And I think I saw enough cases to ascertain that that was, in fact, the practice at Monroe County. That's the way the contract was set up.
Q. So that the question is: Do you think it's fair to give general opinions about the quality of medical care at the jail based solely on your review of cases selected by an attorney who has sued the facility?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: I wasn't giving an overall assessment of medical care at the jail. I was assessing the way that the contract was set up, and that not all of the -- and not all of the cases that I reviewed were handled inappropriately.
My -- I had enough cases to show that the way that the -- the way that medical care was delivered was different than it was -- than it would be on the outside, and that people were allowed to practice outside their scope of practice, and in fact, encouraged to do so.
In my mind, that's inevitably going to lead to bad medical outcomes, not in every patient,

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but to some, and I was able to find evidence of -- in these eleven cases of people that should have been -- the care should have been escalated to a higher level that were not.

I think to do a rigorous scientific evaluation of all the cases, I don't think would change what I knew about the basic way that the care was set up.

Q. Doctor, is it appropriate for a correctional facility to have correctional staff do intake screening?

A. Yes. It is appropriate to have correctional staff do booking screening.

Q. And they're trained to ask those questions, get information, so that they can communicate that to the provider if there's an immediate need, right?

A. They should be. They should have a policy in place of exactly which patients need a medical clearance at booking.

So they should know exactly if this question is answered yes, or if this happens, they don't even have to call a provider. They just tell the arresting officer take this person to the emergency room and get a medical clearance.

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So all jails, in my opinion, should have a policy and procedure in place for correctional officers to refer to when accepting medical patients, and they should have a policy and procedure in place for what questions are asked and what happens when yes or no questions -- when questions are answered yes or no.

Q. I think if you focus on the question, we can move along a little better, but so I understood your answer to be that it is appropriate in the context of booking screening for the correctional officers to take information from the inmate and communicate with the practitioner about that inmate, correct?

A. Yes.

Q. And you're not testifying that it's never appropriate for a physician or practitioner to give a voice order in the context of correctional medicine?

A. No.

MR. WEIL: Objection to form.

Go ahead and answer.

THE WITNESS: It's appropriate for that to happen in correctional medicine just as it happens anywhere else in outside medicine.

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Physicians in hospitals give voice orders all the time.

Q. (BY MR. KNOTT:) And if -- if a physician receives information and assesses a patient as having hypertension, chronic hypertension, it's appropriate to order administration of a blood pressure medication, and to plan to see that patient later, isn't it?

MR. WEIL: Object to form.

THE WITNESS: Yes, the critical area there is to see that patient later. That's one of the things that was not happening in Monroe County in the cases that I reviewed.

Q. (BY MR. KNOTT:) Right.

And to see that patient later could be to see that patient at the next clinic visit by the practitioner?

A. It could be.

Q. Doctor, is there a phenomenon known as hypertensive crisis?

A. Yes.

Q. And you've written that hypertensive crisis is not an emergency, right?

A. No. So I have written about the idea of a hypertensive urgency is a myth. That's different

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than a hypertensive crisis.

And I was not asked to opine on the practice in Monroe County of giving clonidine for an elevated blood pressures, but I don't agree with that. But hypertensive urgency and hypertensive emergency are two different things, or a hypertensive crisis.

Q. Did you determine whether Advance Correctional Health Care is sued more than or less than other providers?

A. I know that they're sued way more than my company was, even taking into perspective being much larger than my company, and I believe they're sued more than my other company, Centurion, was, even though Centurion is much, much larger.

But I have not done a rigorous evaluation, because I don't know how often they've been sued. I don't know the actual number, so I don't know.

Q. You're unaware of any actual monitoring of that --

A. Monitoring of lawsuits you mean? Where they're counted --

Q. Yeah.

A. -- where a company -- I'm unaware of any

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way to ascertain how many times any one company, say Wellpath, has been sued compared to any other company, say ACH or NavCare. I don't know where to look that up.

Q. And Centurion provided care in prisons, right?

A. Yes.

Q. And you have no knowledge of whether there is data available on the national average for lawsuits against correctional health care providers?

A. I am unaware of that.

Q. And you didn't investigate to determine how many cases filed against Advance Correctional Health Care were deemed meritless, right?

A. I have no way of knowing that. I have no way of knowing that.

Q. Some random thoughts here, Doctor, from my notes, but I think I read an index of your book, and it referenced comfort items.

What is that reference to?

A. Extra mattresses, special shoes, bottom bunks, pillows, things like that that are not really medical items.

Q. They are accommodations that an inmate

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may seek from the medical staff to make them comfortable, right?

A. Yes.

Q. Dr. Keller, do you know if there's a provision in the Advance Correctional contract with Monroe County for CQI services?

A. No.

Q. And you know from review of the statistics that were discussed at CQI meetings that ACH practitioners would ship inmates to the emergency room for care, right?

A. Yes.

MR. WEIL: Objection, form.

Go ahead and answer.

Q. (BY MR. KNOTT:) And do you have any basis to judge whether the number of times that they were sent to the emergency room in 2019 or 2018 was appropriate for the population?

MR. WEIL: Object to form.

Go ahead and answer.

THE WITNESS: Well, I don't think that that's a question that's possible to answer. As a matter of fact, I don't think there's any published correct number. It depends on how many emergencies one gets, or how many things that should be sent to

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an emergency department, and that depends on a lot of factors.

So I don't think I can answer that question.

Q. (BY MR. KNOTT:) Are you aware of any basis to believe that Advance Correctional staff were admonished or coached not to send patients out to an emergency room?

A. Not overtly, but in the training where they were trained to -- that incarcerated people complain more than other patients, and are trying to basically game the system to get comfortable, I think if someone believed that, that they would inevitably tend to think that a complaint of chest pains, say, hasn't -- would be due to anxiety rather than a heart attack, and that is going to lead you to send people -- not send people out who should be sent out, if you believe that training.

Q. So to answer my question, there is no evidence that ACH administration admonishes the staff and tells them not to send patients to the emergency room?

A. Not that I have seen.

MR. WEIL: Object to form.

Q. (BY MR. KNOTT:) And what you believe is

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that the training has the potential to create a culture where the practitioners may base their clinical decisions on -- on some sort of unconscious bias, right?

MR. WEIL: Object to form.

THE WITNESS: Not just the practitioners, but also the nurses who will interpret someone with chest pain and shortness of breath as having anxiety and give them Hydroxyzine without ever calling a practitioner.

MR. KNOTT: Is everybody doing okay?

THE WITNESS: I would like to take a five-minute break, not a long one, but I want to go back to the bathroom, if I may.

MR. KNOTT: Okay. We'll do that.

(A brief recess was had.)

Q. (BY MR. KNOTT:) Dr. Keller, I just wanted to follow up on that -- the end of that discussion we were just having.

I understand that you believe that the training that ACH provides about the difference between inmates and patients in the community violate the standard of care, right?

A. I don't mean -- no. That doesn't -- that isn't exactly right. I think it's wrong, and

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that it will inevitably lead people who believe it, I don't know that everybody was taught it actually believes it, for people who believe it, it will result in a tendency to discount the medical complaints of incarcerated people and to ascribe those medical complaints to benign conditions which maybe in most cases it's not going to cause a problem, but in some cases it's going to have them miscount -- misdiagnose, misconstrue, and avoid sending people out. And it's that act that is a violation of the standard of care.

Q. Okay. So the training is factually wrong, you believe, right?

A. I believe the training is factually wrong.

Q. And you believe that it has the potential to create bias that would impact the practitioner's exercise of their clinical judgment, correct?

A. Yes. I think it can impact medical judgment in a detrimental way.

Q. I'm sharing my screen, Doctor. Are you able to read it?

A. Yes.

Q. This is Monroe County 2617, and we can

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mark this as Exhibit 89, CQI notes for --

(Exhibit 89 was marked for identification.)

MR. WEIL: Doug, was Exhibit 88 the report?

MR. KNOTT: It was the invoice. I didn't mark the report or the CV.

MR. WEIL: It's MC2618 through what?

MR. KNOTT: Well, I guess it's seventy-five pages, so I only mean to talk about a couple of pages here. So it's through 2691. And we can treat it as a single exhibit.

Q. (BY MR. KNOTT:) So, Doctor, you agree with me that your knowledge of the ACH CQI process is limited to what you learned from Monroe County, correct?

A. Yes. And also the fact that I saw no evidence of anything different being done in the other counties, but mainly the Monroe County.

Q. Well, you weren't given any CQI documentation from any other counties, were you?

A. No. There was no indication of any -- I received no other CQI documents.

Q. And your characterization of the CQI program is just a discussion of statistics only,

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correct?

A. Overall, yes. It's a discussion of statistics. I didn't see any evidence of formal CQI process studies or outcome studies or sentinel event evaluations or stuff that I would expect at a CQI meeting.

Q. So I just want to get you to look at an example on page 2617. One of the action items is jail administration has received and approved new medical intake questions.

That's not a discussion of statistics, correct?

A. No, that's not a discussion of statistics, but it's also not a CQI unless it came out of a CQI study.

Q. And are you referring to CQI that arises -- can only arise out of patient outcomes?

A. No. There are -- they are NCCHC defines -- well, there's many aspects to CQI, but as far as studies go, they define outcome studies and process studies, two different kinds of CQI studies. And if you want to be NCCA certified, you have to do both quarterly.

Q. And are you aware of any sentinel event at Monroe County Jail that would have changed the

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outcome for Ms. Boyer if there was CQI conformed to your standard?

MR. WEIL: Object to form.

Go ahead and answer.

THE WITNESS: A specific patient? Are you asking me about if there is a specific patient where since a CQI sentinel event study wasn't done, that directly led to Ms. Boyer's death? Is that what you're asking? I didn't understand, I guess. No, I didn't. I'm not aware of any specific patient like that.

Q. (BY MR. KNOTT:) And are you aware of any sentinel events at the Monroe County Jail other than the Schmieder case and the Boyer case?

MR. WEIL: Object to form.

You can answer.

THE WITNESS: The Xiong case should have -- is a sentinel event, should have been a sentinel event. The Aaron Oliver case should have been a sentinel event.

Q. We'll talk about those in a second.

So you reference the Xiong case. Can you tell me the source of your records for the Xiong case? Can you tell me the Bates range?

A. No. I cannot tell you the Bates stamps

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on the Xiong charts off the top of my head.
Q. So I just want to make sure you looked at the same records that we looked at.
How would I do that?
Steve, is it in the spreadsheet that you sent?
MR. WEIL: I believe --
THE COURT REPORTER: Counsel, I can't hear you.
MR. WEIL: -- not on the spreadsheet. It's among the documents that we provided to Dr. Keller in the medical records.
MR. KNOTT: I didn't hear you.
MR. WEIL: It's not in the spreadsheet, the Monroe County Medical Review spreadsheet. It's in documents we sent to Dr. Keller.
THE WITNESS: So I've got it pulled up on my computer, the records that I had; and, let's see, it looks like the first Bates stamp says 0003047. And then it goes on for -- I can't remember how many pages it is.
Q. (BY MR. KNOTT:) It's important, Doctor, could you scroll to the bottom of that?
A. Okay. All the way to the bottom, it's still loading, downloading. The last one I have is

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003145.
Q. So you make the statement in your report that at the hospital it was important that Mr. Xiong was experiencing a heart attack.
Can you tell me the basis for that fact?
A. Well, I -- I did not review the hospital records, so that is something that I obtained maybe from the spreadsheet I got, I guess, from counsel. Or maybe --
Q. Were you provided records other than the Monroe County Jail for Mr. Xiong?
A. Records from the Monroe County Jail? Yes. That's what I'm looking at.
Q. Other than --
A. That's what I'm looking at right here, and there might have been -- yeah. I don't remember already specifically where I learned that he had been diagnosed with a myocardial infarction at the hospital. I don't remember now.
Q. And what are you looking at now, Doctor?
A. I'm just finding Mr. Xiong on my -- in my report that's on page 11, and then I'm in the middle of Mr. Xiong's chart, so I'm ready for wherever you want to reference me.
Q. And what I'm looking for, Doctor, is the

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source for your knowledge or belief that he was -- experienced a heart attack?
A. I don't remember specifically where that knowledge came from. I believe -- yeah. I don't remember exactly where that knowledge came from.
Q. Okay. Would it be important to your analysis of the case if there was no evidence that he did have a heart attack?
A. No. No. It doesn't matter if he had a heart attack or not at the hospital.
A lot of people -- that's actually a mistake to say: Well, we didn't find a heart attack so we should never have sent him to the ER in the first place. That's one of the things that I train on. If you don't get to do retrospective analysis, Mr. Xiong should have gone to the ER the day -- at least the day before he went whether or not he had a heart attack or not.
Q. Okay. Let's look at what you wrote about Mr. Xiong on page 11. You said he was booked into the jail on December 6th, 2019.
So that would be a couple weeks before Boyer occurred, right?
A. Yes.
Q. And looking at the records on your

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screen, Doctor, in fact, he was booked into the jail in 2016, not 2019, right?
A. Well, he was booked several times; but yes, you're correct. That is a mistake I made in my charting.
Q. That was an incorrect statement of fact in your charting, right?
A. I wrote 2019, when it should have been 2016.
Q. And he had elevated blood pressure at booking and the practitioner asked that his blood pressure be monitored for three days, and he refused to have it monitored, correct?
A. I don't remember that he refused to have it monitored. I don't recall seeing a -- seeing a refusal form.
Q. And when Mr. Xiong presented on the 30th of December, he reported that he believed his pain was related to spicy noodles, correct?
A. Yes.
Q. And your testimony is that if an inmate eats spicy noodles and comes to the staff saying that he is having pain related to spicy noodles, he would require transport to the emergency room?
MR. WEIL: Object to the form.

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THE WITNESS: Well, no. That's -- I would not -- I would not frame it in that way.

So patients often say, you know, in my emergency room career, patients would come in often saying I'm having chest pain, and I think it's something I ate. Boy, that is really common.

And so you don't immediately say: Oh, yeah, it was something you ate, so we don't need to do anything, go home.

So I think the main thing is that he sought out medical care, or he sought medical care based on chest pain, and when asked, What do you think?

Well, maybe it was the spicy noodles.

Well, that doesn't matter. He had chest pain.

Q. (BY MR. KNOTT:) Is the patient's description and belief about the source of the pain relevant to the analysis?

A. Maybe. Maybe not. You certainly don't stop there.

Q. So your testimony is that Mr. Xiong should have been transported to the emergency room on December 30th?

A. Yes. So he had abnormal vital signs, a

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heart rate of a hundred fourteen, elevated blood pressure.

On the differential diagnosis, he's -- he's -- he's at high risk based on his age, and you can't just ignore his abnormal vital signs or the fact that he thinks that his chest pain was due to spicy noodles.

I don't think -- if he was any other place in the medical spectrum, if he went to an urgent care center or his family physician or an ER and said, I'm having chain pain, his blood pressure's elevated, and he's of -- he's of the age he is, they would -- even though he says I ate spicy noodles, they would not turn around and say: You're okay, and send him home. They do a workup, and the workup starts with doing a differential diagnosis that is based on a history and a physical exam.

So no. Only a cursory history was done. No physical exam was done. No attention was paid to the vital signs. And just to ascribe it as, okay, you've got indigestion, well, that's going down to the very bottom of the differential diagnosis. That's ignoring the things that could be causing this that could kill him.

Matter fact, he could have just died the

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next day instead of just having chest pain and being sent to the ER.

Q. So your testimony is that a forty-eight-year-old who comes to the staff and says he's got pain related to spicy noodles and points at the pain in his bicep, that GERD or acid reflux would be the bottom of the likely explanations?

A. I would say that --

MR. WEIL: Object to form.

THE WITNESS: I would say that the appropriate response to that complaint is for him to get -- to see a medical provider who would do a detailed history like: When exactly did the pain start? Does it come or go? Is it anywhere else? Have you ever had it before? Does it burn in your chest? Is it heavy in your chest? On and on and on and on, and the appropriate questions to ask.

And then an examination, which includes palpating the belly, for example, to see if he has pain in the -- where you would get pain from indigestion versus listening to his lungs and heart, and then if you get abnormal vitals saying, Why are they abnormal, and repeating them or evaluating them in some way.

If I was evaluating this guy in an

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urgent care center as a physician, I would say he needs a workup. And the workup would be -- well, that history and a physical, but he would go beyond that in needing some sort of testing.

So yes, he should have gone to the emergency department.

But even before the emergency department, it certainly would have been appropriate for the practitioner on duty to come to the jail at this time and see him. That would have been an appropriate response.

It was not elevated to the appropriate levels, and there were two places it could have gone. It could have gone to the -- practitioner goes to the jail and sees him, and then does whatever, does the evaluation, or it could have been send him to the ER.

Q. Now, you're opening a different topic here, Doctor. You're not saying that you, as a contracted physician for your company, were required to come to the jail every time you got a call, right?

A. No. But a call like this, we would have gone to the jail. I've got a patient with abnormal vital signs and pain in his late forties and --

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Q. And based on what you're able to see there, you don't have any evidence that it was anything other than indigestion or acid reflux, true?

A. Sure. I mean, why would indigestion or acid reflux give you a heart rate of a hundred and fourteen? It wouldn't.

Q. So are you ready to testify, Doctor, to a reasonable degree of medical probability within your field that Mr. Xiong actually experienced a heart attack?

A. At that moment in time, no. I think that Mr. Xiong needed to see a medical practitioner at that point in time. And I'll say that very strongly. He should have gone to see a medical practitioner at that point in time. Medical practitioner could have gone to the jail to see him, or he could have been sent out to see a medical practitioner.

Q. And he was sent out in the morning and you don't know the outcome.

A. He was sent out in the morning, and it doesn't matter what the outcome was. He was sent out in the morning when he continued to complain and it got worse.

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Q. Mr. Schmieder passed away in 2016, right?

A. Yes.

Q. And you're unaware of any deaths at the Monroe County Jail other than Boyer and Schmieder that you attribute to ACH practices, correct?

A. I didn't look at the three suicides, and I don't know if ACH was responsible for mental health care or if any of those suicides -- I didn't look at them, so I don't know if any of them had any other medical overlay to them. But there were three other deaths, but I'm not aware of any beyond those five.

Q. So between 2016 and 2024, you're aware of two deaths at the jail that you believe may be related to ACH practices.

A. That's two too many.

Q. Can you answer the question, Doctor?

A. I'm aware of -- I evaluated these two deaths, and I'm not aware of any others.

Q. And you're not able to determine a cause of death of Mr. Schmieder, are you?

A. Well, I believe the autopsy, the medical examiner attributed it to respiratory failure.

Q. Actually, I think the cause was

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undetermined, but your assumption is that it was attributable to respiratory distress, correct?

A. He did have respiratory distress before he died.

Q. At any rate, you're not able to give an opinion about what was his cause of death, true?

A. I would -- I would defer to his autopsy.

Q. And you wrote that his -- that many of the medications he brought to the jail were denied, including his steroid inhaler and pain medication.

I read that correctly on page 10 of your report?

A. Yes.

Q. Albuterol inhaler is a steroid inhaler, isn't it?

A. No.

Q. What is it?

A. It's an alpha agonist. It's a rescue inhaler. It's a bronchodialator. It's a different class of drugs.

Q. He was taking -- he was using an Albuterol inhaler, correct?

A. Yes. He had an Albuterol inhaler that he was allowed access to.

Q. And he was allowed access to Combivent

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Respimat, right?

A. I don't remember the exact ones, but the exact ones -- the exact meds. Let's see, yeah. He was not allowed access to his mometasol flouride inhaler.

Q. And how is that different than Proventil, mometasone, Combivent, and Albuterol, which he was allowed?

A. It is a long-acting steroid in a bigger dose. It's something that is kind of the mainstay of therapy for people with COPD and asthma. It's an important drug.

Q. Which was -- which drug was that?

A. The mometasol, the steroid inhaler that he wasn't allowed to have. I don't understand why he wasn't allowed to have it, but he wasn't allowed to have it.

Q. Okay.

A. The issue there, actually, is also not coming to see him and actually interviewing and seeing him and asking: Why are you on these meds? But he never saw a practitioner.

So if you're going to screw around with his meds, you probably should see him in the flesh and do an exam.

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Q. And Mr. Schmieder refused a medical evaluation, according to your report?

A. Well, nobody went and asked him why he was refusing, and nobody went back and asked him a second time if I can do it on a different day.

So it isn't enough to just -- he's there for a month. It isn't enough to say: Well, he doesn't need -- he's refused, so he's refused forever. That's not appropriate. He's still your patient. Even though he's refused, he's still your patient. You go back and check on him again.

He didn't refuse wellness checks. He didn't refuse anybody coming and saying: Can I take your vitals and see how you're doing.

Q. Doctor, you have no reason to believe he was incompetent, right?

A. No.

Q. And he never asked for the medications that he was denied, right?

A. No. There are a lot of people that -- that don't --

Q. Can I get an answer?

A. I said no.

Q. He never asked for --

A. I said no, and I was going to add a little bit.

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Q. And do you think that the nursing staff didn't have a conversation with him when he was refusing and signing refusal?

A. I don't see any -- I didn't see any notes of their conversations with him. If the nurses had a conversation, you know, one of the things I taught, and I believe is the medical standard of care that would happen in a hospital, is every interaction between a medical professional and a patient generates a note of what happened of some kind. So if the nurses --

Q. Like a refusal form?

A. If the nurses went up and talked to him and said, How are you doing -- I'm talking about later. I believe that you meant later. If the nurses went up and saw him later and said, How are you doing, I would expect that would have generated a note.

And besides the refusal form, I don't see that they made any investigation of why he was refusing.

Q. And he refused -- strike that.

I need to know, in page 11, the basis for you to say that the medical staff were aware of

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his, quote, troubled breathing the night of his death, the night before his death.

A. Okay. So if I remember correctly, the investigator conducted interviews with the inmates who stated that before his death he was having trouble breathing, and medical staff were aware of this problem.

Where that came from exactly, I think it came from -- I'm not sure -- I think it came from the in-custody death summary, so I'm looking for it.

Q. You faded there on me. It came from where?

A. I believe it came from the death summary, but I'm looking for it.

By the way, when -- the refusal forms weren't signed by Mr. Schmieder, which I think was odd, but why wouldn't he sign?

But be that as it may, I'm not seeing where the in -- his fellow inmates notified medical staff.

Q. You're not seeing that.

A. No. I can't find it at this point in time.

Q. Okay. I shared the screen of the

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medication verification form from the day Mr. Schmieder was booked.

Which of his vitals were abnormal?

A. His heart rate is a hundred and one, that's abnormal. His respiratory rate is twenty-two, that's abnormal. His blood pressure is okay. He doesn't have a fever.

Q. Okay. Pull up your records for Mr. Mendoza.

A. I lost it. Oh, they're not in deaths. That's why.

Q. Are you with me, Doctor?

A. I'm looking for Mendoza. I've seen some of the other patients go by, but I haven't seen Mendoza yet.

MR. WEIL: Dr. Keller, I'm not sure how to help you find it. I pulled it up from the e-mail I sent you.

THE WITNESS: I've seen lots of other ones: Coleman, Date, Hodgkins, Luthke, Mask, Xiong.

MR. WEIL: You're getting there. You're getting there on that list.

THE WITNESS: And then a bunch of them, it isn't clear to see. It isn't clear exactly who

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it is, Eli Brush, without opening it.
So I need to open them all, I guess.
MR. WEIL: You should be able to click right at the top and just scroll through them.
THE WITNESS: Hanson. Well, if you found it, where is it in the list?
MR. WEIL: Yeah. I'm going to -- let me see here, can we go off the record real quick? I think I can get it to him pretty quickly.
Is that okay, Doug?
MR. KNOTT: Sure.
MR. WEIL: Okay. Thanks.
(Pause in the proceedings.)
MR. WEIL: Are you ready to go back on, Doug?
MR. KNOTT: Yeah.
MR. WEIL: Okay.
Q. (BY MR. KNOTT:) So, Doctor, I'm sharing the screen for an event from August 25, 2012. If you take a look at that, it's -- do you agree that this is the event that you described in your report at page 11?
A. Uh-huh, yes. It was -- actually, it was the one earlier is the one I'm really talking about where it says -- this is one -- the second one. He

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was complaining the second time.
Q. Okay. And actually, Doctor, you wrote in your report that it was August 25, 2019. In fact, per MC39943, this is an event that occurred in 2012.
Okay?
A. Okay.
Q. So you made a mistake of fact as to the year that this occurred, right?
A. Yes.
Q. And then with respect to the 2019 incident, August 16, 2019, page MC Medical 40219, It's a nursing note.
Is this the source of your information for the second half of your note?
A. I believe so.
Q. Paragraph 3, page 11, Doctor?
A. I believe so.
Q. And you wrote that the LPN diagnosed him with anxiety.
First of all, she's an R.N., right?
A. Okay.
Q. Correct?
A. This note is signed by an R.N., yes.
Q. And is the difference in training

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between an R.N. and LPN significant to you, Doctor?
A. Yes.
Q. You repeatedly refer to the Monroe County Jail R.N.s as LPNs.
Is there a reason for that?
A. Well, are they all R.N.s? When I used LPN, I based it on what I was seeing in the -- seeing on their signatures.
Q. Okay. So, Doctor, there's no report of chest pain in this note, correct?
A. I am not sure if that is the one that I was referring to, but there -- yes. This is not the right one. It was the event that happened earlier where the anxiety he had mentioned earlier, he did not want to take his PRN Hydroxyzine. It's the interaction where the PRN Hydroxyzine was prescribed.
Q. What are you reading, Doctor?
A. I'm reading right in the middle where it says: I asked patient about the anxiety he mentioned to me he had been feeling earlier today. He agreed he was feeling anxious. He did not want to take his PRN Hydroxyzine.
So it was already prescribed. So it was

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earlier than that. It was an earlier interaction than this one.
Q. Well, you don't -- you don't reference Hydroxyzine in your report.
A. No. I don't mention Hydroxyzine in my report.
Q. And so are you saying there's another significant event on August 16th, 2019, where the care was mismanaged?
A. There is an incident, and I'll find it if I look -- if I continue to look, but there was an incident where Mr. Mendoza wasn't -- here he's complaining of repeating reporting his claim. It was -- well, maybe it was this one. I don't know.
The one I remember seeing was the nurse had a diagnosis of anxiety. I don't think this is the same one. And the one where the Hydroxyzine started. So I don't believe that's the same one that I referenced.
Q. So if there's another note on August 16, 2019, referencing the starting of Hydroxyzine, then that's what you're referring to. Otherwise you're mistaken about there being a note describing a diagnosis.
A. I don't believe I am mistaken, and I

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don't believe -- no. I don't believe I'm mistaken about there being another note, and I don't believe I'm mistaken about having a diagnosis of anxiety, and the beginning of Hydroxyzine.

Q. Okay. So there's no reference in the note that's in front of you 040219 to a nurse making a diagnosis.

Do you agree?

A. There's no reference there as to the nurse making a diagnosis in that note.

Q. And what she describes as the inmate had mentioned anxiety to her earlier in the day. I'm putting my highlighter on it, my mouse on it. Right?

A. Yes. That note mentions that. I don't believe that's the note I was referring to.

Q. Okay. And he reported drinking a lot of coffee, at least in the note that I'm referring to, right?

A. Yes.

Q. And he reported that he agreed he is feeling anxious, right?

A. Yes. Even that being the case -- even that being the case, though, this is something that should have been elevated to a practitioner, maybe

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not immediately, but a practitioner should have seen him.

Q. On his report of anxiety that resolved in ten minutes?

A. With a prescription of Hydroxyzine, which is a medicine that needs to have a practitioner prescribe it.

Q. You don't have any evidence of a cardiac condition for Mr. Mendoza, true?

A. No.

Q. And no evidence that he complained about his care, right?

A. No.

Q. And no evidence that this report on August 16, 2019, was anything other than anxiety, true?

A. No. I have no evidence -- I don't know whether that is true or not. I do think, though, that there are other things in the differential diagnosis that would cause rapid heart rate and not being able to breathe that are not anxiety, and proper management is to rule them out first.

Q. As far as you know, it was anxiety and the nurse was correct.

A. I don't -- I don't know. Neither does

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she.

Q. I want to talk to you about Elizabeth Coleman.

A. Okay.

Q. Okay.

A. I've got Elizabeth Coleman open.

Q. And your criticism of the staff is that she was not properly worked up for seizures; is that correct?

A. Correct.

Q. She was not seen by a practitioner. In fact, I'm showing you page MC Medical 011710. Ms. Coleman was sent to the emergency room the night she fell, right?

A. Yes.

Q. And do you know what recommendations the emergency room had for her?

A. Well, let's pull it up. So I've got -- if you're looking at the med list that they sent back, the after-visit summary, that's where I'm at.

Q. Me, too, Doctor. So in the after-visit summary, she was seen for a head injury. She was given a CT and the recommendation was acetaminophen, correct?

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A. No. I got the medication list as being copaxone, metoclopramide, Albuterol, and topiramate.

Q. Right. And the topiramate was restarted at the recommendation of the R.N. in communication with the nurse practitioner after this workup at the hospital, right, Doctor?

A. Right. And the nurse practitioner at the jail never saw her. This is another reason why the nurse practitioner should have seen her.

She went to the hospital with a head injury. Those patients who have an injury bad enough that they need to go to the ER, you can't just blindly assume they're going to get better. Some don't. And that should have generated a visit with the nurse practitioner. It did not.

Someone that had just started a new prescription for topiramate, she would have been on, what, seizure chronic care and should have been seen by a practitioner, and she was not.

Q. So she had fallen on the 8th and had been to the emergency room, right?

A. Yes.

Q. And she had a CT, and was sent back to the emergency room -- or sent back to the jail,

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right?
A. Yes.
Q. The hospital listed her medications as including topiramate --
A. Yes.
Q. -- right?
And you're critical of the continuation of the topiramate?
A. No.
MR. WEIL: Object to form.
THE WITNESS: I'm critical of the fact that she had never seen a practitioner. So, for example, here on page -- let's see, I don't see a Bates number on it, but I'm looking at a narrative progress note 9-13-19. Nurse was called to pod by jail staff because patient was having a seizure. She was able to stand and walk back to her -- she was not visibly shaking. She saw flashing lights. She calmed down, asked questions, never referred to a practitioner.
Q. Can I share on the screen with you, Doctor? This is MC Medical 011711.
Can you see this?
A. Yes.
Q. And it's a medical progress note, MPPA.

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Do you see that at the top?
A. Uh-huh.
Q. January 27, '20, and signed by a nurse practitioner.
So do you agree that your criticism that this patient was never seen by the nurse practitioner in person is baseless criticism?
MR. WEIL: Object to form.
THE WITNESS: The criticism I have with that -- okay. I guess I'll have to -- I'll admit that she was seen by --
Q. (BY MR. KNOTT:) Can we start with -- can we start with if you're critical with the nurse practitioner for never seeing her, then you're wrong? Can we start with that?
MR. WEIL: Object to form.
THE WITNESS: It appears that the nurse practitioner saw her.
Q. (BY MR. KNOTT:) So the criticism you articulated in paragraph four is inaccurate.
Do you agree with that?
A. Yes.
Q. And, Doctor, did you receive information from Mr. Weil's firm that Ms. Coleman was never seen by a practitioner?

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A. No. That was -- that was me. I evidently missed that -- that form. That mistake was my mistake, not Mr. Weil's mistake.
Q. I want to try to move along through these. I generally -- I know you don't think it's important, but I want to ask you whether you're aware of the outcome for these patients. So I just want to get that factually in the record.
So Troy Maske, you describe his report of heartburn, and he was given Tums in 2019, and you say he should have had a cardiac workup.
Is that your criticism?
A. Well, my criticism starts before that on 6-14-19, where he was given an emergency dose of clonidine, and if he's sick enough to get an emergency dose of clonidine, he needed to have -- he should have had -- he should have had a workup.
I mean, he should have been seen face-to-face by a practitioner, and if he really needs an emergency dose of clonidine, he's that sick, he needs face-to-face workup with a practitioner, so he should have been sent to the hospital for a cardiac workup, I guess, at that point.
And then again, he's -- the nurse

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practitioner never saw him, as far as I could see on -- after he -- after he complained of chest pain and was given -- had abnormal vital signs and was given Tums.
Q. And you have no evidence that Mr. Maske actually had a cardiac condition, right?
A. No.
Q. And you have no evidence that Mr. Maske asked for or felt the need for more treatment, right?
A. No. That's irrelevant. The nurse practitioner --
Q. I understand that. I'm trying to get the facts --
A. On 6-14, the nurse practitioner thought he was so sick that he needed an emergency dose of a cardiac medication, and yet never saw him later and never sent him to the ER.
So then he complains again on a second time of chest pain, and this time he got Tums, which is not an emergency medication, but nevertheless, he needed to have a face-to-face with a nurse practitioner --
Q. So --
A. -- or go to the ER.

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Q. I'm just trying to get these facts of record, and there's no evidence that Mr. Maske had actually had a cardiac condition, right?
A. Right.
Q. And there's no evidence that he had an untoward outcome from his complaints of chest pain in 2019, correct?
A. Correct.
Q. And you described -- well, strike that.
Mr. Hanson was sent to the emergency room for medical clearance before he was booked into the jail, right?
A. Okay. So let's go to Mr. Hanson.
Q. It's in your report.
A. Right.
Q. Take your time.
A. Right. He went to the emergency department for hemoptysis just right before he was booked into jail.
Q. I'm trying to find the document where you say that the nurse diagnosed him with acid reflux.
At any rate --
A. I was on the wrong page.
Q. -- there's no evidence that you're aware

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of, Doctor, that Mr. Hanson had a cardiac disorder, true?
A. No.
MR. WEIL: Object to form.
Go ahead and answer.
MR. KNOTT: Excuse me.
THE WITNESS: I have no evidence that he had a cardiac abnormality.
Q. (BY MR. KNOTT:) And no evidence that Mr. Hanson felt that he needed more treatment or to go to the hospital, right?
A. No.
Q. And no evidence that Mr. Hanson had an untoward outcome, true?
A. No.
Q. Not true?
A. No. I have no evidence that he had an untoward outcome. But the fact that his care was not elevated to a nurse practitioner of some kind, that the LPN didn't even call the practitioner, didn't put him on the schedule to see a practitioner, that was inappropriate medical care. The fact that he had no bad outcome doesn't make it okay.
Q. Sometimes, Doctor, the inmates are put

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on the schedule to be seen at a clinic, and they're discharged before that clinic date comes around, true?
A. That is true.
Q. I'm going to share a screen for Eli Brush, and your comments on Mr. Brush are in reverse order, I think. With respect to the 2019 event, 12-21-2019, you say: Mr. Brush was seen by an LPN who diagnosed anxiety and prescribed Hydroxyzine without calling a practitioner.
So that would be reflected in this narrative note, wouldn't it, Doctor?
A. I can't -- can you enlarge that? I can't read it. Okay.
Q. And I don't -- first of all, this was an R.N., not an LPN as you've described her.
A. Right.
Q. And I don't see anywhere in her language that she diagnosed him with anxiety, do you?
A. Okay. I'm not sure if that is the one that I saw, but it must have been. That's the date. So no, I don't see where she diagnosed anxiety there.
Q. And your criticism is that the R.N. diagnosed anxiety and prescribed Hydroxyzine without

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calling a practitioner, and that's not true either is it, Doctor? This is a telephoned voice order from the nurse practitioner, right?
A. I don't think that that is the -- that that is the right note that I looked at. Doesn't look like the right note. I would have to find the right note.
Q. Do you agree that Hydroxyzine was ordered as a result of a telephone order with the nurse practitioner --
A. Yes.
Q. -- on December 21 of 2019?
A. Yes.
Q. And there's no evidence that Mr. Brush had a cardiac disorder, true?
A. No.
Q. No evidence that Mr. Brush felt the need for more treatment or to go to the hospital, true?
A. True.
Q. And no evidence that Mr. Brush had an untoward outcome, true?
A. True.
Q. Do you have another criticism about the treatment of Mr. Brush on February 20, 2020? I'll tell you, I couldn't find any treatment on

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February 20, 2020, but this is February '22.
And assuming this is what you're referring to, there's no reference in this document to Mr. Brush reporting chest pain.
A. Well, the quick, dull cramp, I guess. That's the one I'm looking at.
Q. It doesn't say where that is.
A. Well, let's go down. If that's the one, yeah, no major medical concern. So I assume that that was chest pain.
Q. Okay. His vitals are normal?
A. Yes.
Q. Sitting comfortably in the chair with no physical distress?
A. It should have been elevated to either go to the hospital or to see Ms. Pisney later, which I don't believe he did.
Q. All right. Again, well --
I'm going to share with you a record for Mr. Hage, and your criticism is he was seen by an LPN who diagnosed withdrawal and prescribed Hydroxyzine without calling a practitioner?
Do you agree with me, Doctor?
A. Yup, yes.
Q. It wasn't an LPN, it was an R.N. that

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interacted with him that day, right?
A. Yes.
Q. She didn't diagnose withdrawal. Her assessment was possible withdrawal, right?
A. That's shaving a point, but she thought he was having withdrawal.
Q. And your criticism that it was prescribed without calling a practitioner is erroneous because it says telephone order of Dr. Schamber, right?
A. Yes, that's correct.
Q. And Dr. Schamber signed it the next day.
A. But didn't see the patient.
Q. With respect to Mr. Hage, there's no evidence of an actual cardiac disorder; is that true?
A. No. I think the question on Mr. Hage was one of withdrawal.
Q. So that is a true statement by me?
A. Yes.
Q. And there's no evidence that Mr. Hage thought that he needed more treatment or to go to the hospital, right?
A. No.
Q. And no evidence of a bad outcome,

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right?
A. No.
Q. And with respect to the lump on Mr. Hage's back, you don't have any evidence that, in fact, it was a malignancy, correct?
A. No.
Q. And isn't it a true statement that it's unlikely malignant if it's movable?
A. Well, that might be true. It's just that an R.N. or an LPN, a nurse, shouldn't be the one making that determination. It should be a practitioner making that determination.
The nurse might have been right, but she's not the right person to be making that determination. She should have elevated that to a practitioner.
Q. Doctor, if you look at the note of that, it's MC Medical 22552, it's actually Dr. Schamber who's relating that it's most likely not malignant if moveable, true?
A. Dr. Schamber needed to examine the patient himself. His -- that comment may or may not be right, but he needs to examine the patient.
Q. I want to ask you about Erin Oliver.
Sir, with respect to this Erin Oliver,

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if I understand your narrative correctly, she reported a decaying tooth. Nurse Pisney saw her, and identified it as a cavity in the middle of the tooth space on November 29, and she was seen at the dentist on January 2, 2020.
A. Right.
Q. And I assume that you're not qualified to give an opinion that the four teeth extraction could have been avoided if she had been seen earlier?
A. No, I am not, but I am -- but I can say that it should have been elevated to see a dentist far sooner and that her pain and suffering during that month could have been lessened if it had been elevated to a dentist sooner.
Q. Doctor, do you have trouble getting dentists to treat prisoners in Idaho?
A. No.
Q. Do you ever have delays in getting prisoners out for the dental care they thought they needed?
A. No, I haven't. I would expect if that was the case in -- on Erin Oliver, that a nurse or somebody would have written a note that said I called a dentist, and earliest we can get Ms. Oliver

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in is such-and-such, and I've informed Ms. Oliver of this. I didn't see any such note. It might be that what you say is the case, but I didn't see any evidence of it.

Q. I'll share with you MC Medical 42706. It is a report from Ms. Oliver, sick call request, December 31. And the response is made the same day saying: Erin, an appointment has been made for you to be seen at the dentist. Due to jail policy, medical cannot tell you the date. And then it says: Patient seen by the nurse practitioner?

A. Yeah. My criticism isn't that she eventually got to the dentist. My criticism is she should have been elevated to the dentist far earlier.

If she could not have been elevated -- you know, if they couldn't have made an appointment on December 7th, December 9th, November 29th, then I would -- if they had written a note, then that would have been one thing. I did not see a note to that effect.

Q. In your discussion of the cases at facilities serviced by ACH --

MR. WEIL: Can we take a quick bathroom break if you're shifting gear?

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MR. KNOTT: Yeah. Yeah, but I'm going to try to wrap up soon here.

MR. WEIL: Okay. Well, your call. I could use one, if you wouldn't mind.

MR. KNOTT: Yes.

MR. WEIL: Thank you.

(A brief recess was had.)

MR. KNOTT: Back on the record.

Q. (BY MR. KNOTT:) Doctor, with respect to the eleven cases at other facilities serviced by ACH, the extent of your knowledge is contained in papers or the records you received from Mr. Weil's office, right?

A. Yes.

Q. And those eleven cases were selected by Mr. Weil, I think some of them were included in the complaint. They were not selected by you, right?

A. Yes.

Q. And, well, with respect to the Monroe County Jail cases, there were, I think, seven of them that you said you had technical difficulties and couldn't open the file.

I assume you are not able to open the file today.

A. Probably not. I haven't looked, but

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probably not.

Q. You don't have any opinions on those?

A. No.

Q. And did you rely -- with respect to the eleven cases from those other facilities, did you rely on the plaintiff's expert or their evaluation of the case?

A. I looked at all the -- all their records myself that I was sent. I also looked at some, but not all of the plaintiff's experts.

Q. Did you look at some of the defense expert reports?

A. No. I don't think I was sent any defense expert reports, so I did not look at any defense expert reports.

Q. Are the records that you received for those eleven cases summarized in some correspondence from Mr. Weil's office?

A. Would you repeat the question?

Q. Yeah. I don't want to repeat the question. It was a bad question.

Were the records from the eleven cases that you reviewed for other facilities, were those abstracted or summarized in some way by Mr. Weil's office?

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A. Mr. Weil's office did do a summary on them, but the records I reviewed were the actual records from the facilities that I was sent plus some autopsy reports and autopsy files.

Q. And I'm sorry if I asked you this, but you didn't read any depositions, right?

A. I read some plaintiffs' depositions, but I didn't -- but I didn't read all of them, and I didn't read any defense depositions.

Q. Why would you choose to do that?

MR. WEIL: Object to form.

THE WITNESS: On the depositions, I relied on the summaries that were provided to me by Mr. Weil's office.

MR. KNOTT: And, Mr. Weil, have those summaries been provided to us?

MR. WEIL: We provided you the documents --

THE COURT REPORTER: Wait. Speak up a little bit. I couldn't hear you.

MR. WEIL: We have provided the summaries that we provided to Dr. Keller.

Q. (BY MR. KNOTT:) Dr. Keller, a differential diagnosis is not simply the process of ordering the most serious potential cause of

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symptoms at the top, no matter how unlikely, is it?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: Differential diagnosis takes into account likelihood as well as -- as well as lethality and ability to cause morbidity.
So the whole process of developing a differential diagnosis takes into account the most likely things, but also ranks those; so, yes, there is that, but it also ranks them according to which ones are most important to rule out first.
Q. (BY MR. KNOTT:) And the clinician is required to evaluate the report of symptoms in each case to weigh the likelihood of each diagnosis as explaining the symptoms, right?
MR. WEIL: Object to form.
THE WITNESS: The first step in formulating a differential diagnosis is to get a complete history and do a physical exam. It's inappropriate to start speculating beforehand. After you do --
Q. So it's a --
MR. WEIL: Let Dr. Keller finish.
THE WITNESS: After you get your -- do

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the history and do the physical, then is the time to formulate a differential diagnosis based on, yes, the complaints the patient has, but also based on the history that you got and the physical exam that you did that.
Q. (BY MR. KNOTT:) And do you agree that the ordering of the potential diagnosis on a differential diagnosis involves the application of clinical judgment to the facts and circumstances of the case?
MR. WEIL: Object to form. Go ahead and answer.
THE WITNESS: Yes.
Q. (BY MR. KNOTT:) And the manner that you approach the workup to attempt to investigate and find the cause of the symptoms, that involves clinical judgment, doesn't it?
MR. WEIL: Object to form.
Go ahead and answer.
THE WITNESS: Would you repeat that question, please.
Q. (BY MR. KNOTT:) The manner in which the clinician proceeds through the workup to address and investigate the symptoms is a matter of clinical judgment, too, isn't it?

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MR. WEIL: Object to form.
THE WITNESS: Well, to some degree it is, although it has common ground no matter what the patient and what the complaint, and that is that you have gather a history and you do a physical exam.
And then where you go from that depends on what you've learned from the -- from the history and the physical exam.
Q. (BY MR. KNOTT:) Do you agree that anxiety is a cause of Ms. Boyer's elevated blood pressure, shortness of breath, and diaphoresis on Sunday the 22nd, that anxiety would be on the differential diagnosis, at least a potential explanation?
MR. WEIL: Object to form.
THE WITNESS: It would not have been on my differential diagnosis at that point.
Q. (BY MR. KNOTT:) Nowhere on the differential?
A. Maybe low down. But I mean, the idea that anxiety alone in a patient with a high problem -- high risk factor for heart disease, and a related history of cancer and chemotherapy, that that person's diaphoresis, sweatiness, and blood pressure elevation, and all of the elevations, would

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have been due to anxiety, is so low that it wouldn't have even been on my list. It's possible, yes; but it certainly not probable.
MR. KNOTT: All right. I'm going to wrap it up there and let others ask questions while I check my notes.
MR. JONES: I'm happy to go next, John, unless you want to start.
MR. CASSERLY. That's fine. I'll only have about fifteen or twenty minutes when you're done.
MR. JONES: Okay.

EXAMINATION
BY MR. JONES:
Q. Doctor, I'm Andrew Jones. I'm the attorney who represents the Monroe County, and the individual Monroe County defendants.
I'm going to try and move as quickly as I can. I know we've been at this a while. But I do want to ask some follow-up questions in particular about the Monroe County patients whose records you reviewed.
Fair enough?
A. Yes.

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Q. And tell me, how is it easiest for you? I notice when Mr. Knott had pages up that he was sharing on his screen that you more often than not were looking at the laptop that's in front of you at the medical record on the laptop.

Is it easier if I just refer to a Bates number for a particular patient, or do you want me to share on the screen?

A. Why don't you share on the screen because oftentimes I could not find what I was looking for.

Q. Okay. So for Mr. Xiong -- I'm sorry.

So we talked about the episode of chest pain he had on December 30th. And I want to go back to when he was screened into the jail on December 9th. Okay? And I'm sharing on the screen Monroe County 3127 through 31.

You recognize this as I'm moving about --

A. Yes.

Q. -- as the medical screening report for Mr. Xiong?

A. Yes.

Q. It would have been completed at the time he was booked into the jail?

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A. Yes.

Q. And you noted in your report that his blood pressure was high when he was booked, yes?

A. Yes.

Q. One fifty-four over ninety-three?

A. Yes.

Q. And the direction at the time was to administer a dose of clonidine and then recheck his blood pressure over the next several days, correct?

A. Yes.

Q. And I'm showing you now what's been marked as 3083 through 85.

Do you recognize having seen these refusal of treatment forms before just now?

And they indicate that he refused to have his blood pressure checked on the 11th of December and the 10th of December, correct?

A. Yes.

Q. He did have a medical history completed while he was in the jail, correct?

A. Yes.

Q. I'm showing you Monroe County 3087. It's a little hard to tell the date on this, but I understood this was from December 21st of 2016.

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Is that your understanding?

A. Yes.

Q. And his vitals were taken as part of that medical history, correct?

A. Yes.

Q. And was there anything abnormal in those vital signs as of December 21st?

A. No.

Q. And was there any indication of any sort of cardiac or heart problem or abnormality as a result of that medical history completed on the 21st?

A. No.

Q. And then, if we look to -- if we go then to the evening of December 30th, when he first complained of chest pain, I'm showing you Monroe County 3073 through 75, this is the document filled out by the officer as a result of his complaint, yes?

A. Yes.

Q. All right. And Mr. Xiong indicated he had no history of heart disease, elevated blood pressure, or other medical conditions, correct?

A. Yes.

Q. And he indicated to the officer he

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wasn't on any heart medication, yes?

A. Yes.

Q. No history of cocaine usage, correct?

A. Yes.

Q. And he evidently was then asked by the officer how long he had been having the pain, correct?

A. Yes.

Q. And his response was it had just started five minutes ago, correct?

A. Yes.

Q. And he was asked by the officer for his subjective assessment or understanding of what was causing the pain, yes?

A. Yes.

Q. And he indicated that he had eaten spicy noodles, yes?

A. Yes.

Q. And he told the officer he had not had similar symptoms before this, correct?

A. Correct.

Q. And he told the officer the pain came and went, correct?

A. Yes. Which is -- which, by the way, is important.

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Q. That's one of the things you want Mr. Xiong to have been asked, correct?
A. Yes.
Q. And he indicated he described the pain as hot, aching, yes?
A. Yes.
Q. He did not have nausea or vomiting?
A. Yes.
Q. No shortness of breath, correct?
A. Yes.
Q. And there was no pain in his neck, shoulder, or arm, correct?
MR. WEIL: Object to form.
THE WITNESS: Well, he -- except he pointed to his left bicep when asked where he felt the pain.
Q. (BY MR. JONES:) Well, let me ask a better question. When asked if the pain was in his neck, shoulder, or arm, he responded no, correct?
A. Yes.
Q. And when he was asked to show or pinpoint the area of the pain, he put his hand on his left bicep, correct?
A. Yes.
Q. The vitals were measured as shown on the

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form, correct?
A. Yes.
Q. And he had, to the officer's observation, no shortness of breath and no abnormal sweating, correct?
A. Yes.
Q. And when you -- when you testified, I believe -- well, let me put it differently. When you said in your report that his symptoms were consistent with a heart attack, what specifically are you pointing to?
A. Well, first of all, he's -- he's in a high risk category based on his age, near fifty, and the fact that he has high blood pressure, as a matter of fact, his blood pressure was so high he needed an emergency dose of clonidine to bring it down.
He's having -- he's having pain, cardiac pain is felt in the chest, but commonly radiates to the left arm. He's having pain in the left arm. Cardiac pain typically, or very commonly, comes and goes. You get it and it goes away, you get it back. And then he has abnormal vital signs.
So all of that in an emergency room, he would not -- or an urgent care center, for example,

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or doctor's office, he would not just be given Tums for this, he would get a workup. At the very minimum, he should have been in front of a practitioner. He needed to be seen by a practitioner. It should have been elevated to a practitioner.
So the doctor they called, or the practitioner they called, could have come to the jail, or he could have gone out. But either way, he should have been seen by a practitioner based on his presentation.
Q. And is it -- is it acceptable or not acceptable if someone complains of chest pain that started five minutes ago, and the person subjectively attributes to having eaten spicy food to suggest they take Tums or an antacid, and then see if that resolves the symptoms?
MR. WEIL: Object to form.
THE WITNESS: Well, seeing if that resolved the symptoms I don't believe occurred. One of the things what I'd be interested in as a practitioner would be, even more than that, I'd be interested in whether -- if his vital sign abnormalities, how they changed with time.
So if he gets rechecked, and says: Hey,

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did the Tums help? I would want to check his vital signs, too. And it doesn't matter whether the Tums worked or not, if he's still in an emergency room or an urgent care center would get a workup based on the fact that he was high -- that he's in a high risk category.
Q. (BY MR. JONES:) So again, my question was, would it be acceptable or not acceptable with an individual who complained of chest pain that started five minutes ago, who subjectively attributed it to having eaten spicy food, to direct them to take Tums or an antacid, and see if that resolved the issue?
MR. WEIL: Object to form.
THE WITNESS: It would have been perfectly acceptable to give the patient Tums while the doctor was on the way in to see him.
And then when the doctor got there could say: How did the Tums do? Let's see what your vital signs are now, and let me get a more complete history.
Q. (BY MR. JONES:) So do you know whether or not Mr. Xiong complained of any ongoing symptoms before he complained at 7:00 a.m. the next morning?

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A. No. All I have to go on are the documents. I don't have anything indicating anything in between.

Q. And when he complained at 7:00 a.m., he was sent to the hospital, correct?

A. Yes.

Q. And this was discussed a little bit, but I want to be clear, I want the record to be clear. In your report you indicate that at the hospital it was determined that he had been experiencing a heart attack.

Do you have any source for that statement in your report?

A. I got that from somewhere. I don't remember where. And I -- so I can't answer that right now. But I will say it doesn't matter. Sending him to the hospital --

Q. That's not -- we've been at this for quite a while, Doctor, and my question is: Do you have a source for that assertion in your report?

A. I have a source -- I had a source. I didn't just make it up. I'm not -- I can't remember what that source is right now.

Q. And your report doesn't tell us what the source is.

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A. Correct.

Q. And if there's no indication or statement in the medical records that you reviewed that were provided to you, where would you have gotten that? Are you able to enlighten us at all as to where you got that factual assertion?

A. As I sit here I do not remember where I got it.

Q. On the screen is an Excel spreadsheet that Mr. Weil provided to counsel about sixteen minutes before we began this morning.

MR. WEIL: It's not on the screen, Andrew.

MR. JONES: Oh, it isn't?

MR. WEIL: No.

MR. JONES: Oh, I'm sorry. Hang on. Thanks, Steve.

Q. (BY MR. JONES:) Okay. Do you see it at this point, Doctor?

A. Yes.

Q. Do you recognize this spreadsheet?

A. Yes.

Q. And what do you understand it to be?

A. It's a spreadsheet of patients from the Monroe County Jail.

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Q. And who created this spreadsheet, if you know?

A. I don't know specifically who created this spreadsheet.

Q. Do you have a copy of this spreadsheet that identifies what each of the columns in the spreadsheet represents?

A. I have a copy of the spreadsheet. I'm not sure -- I don't remember what each of the columns represents. I'm not sure exactly what you're asking.

Q. Well, what I'm asking you is, what information is shared in column A of the spreadsheet?

A. I don't know.

Q. What information is shared in column B?

A. I don't know the answer to that right now.

Q. Do you understand or know how the individuals who were listed on this page of the spreadsheet are organized?

A. Do I know how the person who prepared this organized it and why it was organized in that way? I don't know. I think it was organized

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alphabetically, but a spreadsheet like that you can change, of course.

Q. Do you know what the information in column F means?

A. I think the information in column F is how significant the person who did the evaluation thought the care was.

Q. And, again, you don't know who did the evaluation for that?

A. No.

Q. And how, if at all, did you use or rely on this spreadsheet in your work?

A. Well, I thought the ones that this person said were appropriate care, I assumed were appropriate care, and I didn't review them.

I reviewed a couple of -- I mainly reviewed the cases that were in the complaint. I think I reviewed a couple that were -- that this person thought were problematic, but that's how I used it.

Q. So for the individuals -- the eleven or twelve individuals who are discussed in your report who were patients or inmates in the Monroe County Jail, did you look to this spreadsheet and rely on the description -- descriptions given in columns G

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and H in your work in this case?
MR. WEIL: Object to the form.
THE WITNESS: I read them. I don't believe that I -- I relied on them. I relied on the medical records.
Q. (BY MR. JONES:) But did you review the descriptions in this spreadsheet for the patients that are discussed in your report?
A. Yes.
Q. And I'm showing you a second page of the same spreadsheet.
Have you seen this page before, or did you look at this page as part of your work?
A. No, I didn't look at the second page.
Q. And do you know who Essence and Jessie are?
A. No.
Q. So I want to shift gears to Mr. Mendoza. Jose Mendoza.
Sharing my screen again.
Do you see the screen?
A. Yes.
Q. So in your report -- and Mr. Knott asked you some questions about this -- but in your report, you talk about incidents that occurred on

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August 16th of '29 (sic), correct?
A. Yes.
Q. Where Mr. Mendoza complained that his heart was beating too fast and that he could not breathe, yes?
A. Yes.
Q. And your description in your report is about an LPN diagnosing him with anxiety, correct?
A. Yes.
Q. So what I've got on the screen, that's a medication administration record for Mr. Mendoza, yes?
A. Yes.
Q. And it's pretty faint or pretty small, but at the bottom right above the Bates number, it indicates this is from July of that year, yes?
A. Yes.
Q. So before the situation on August 16th, correct?
A. Yes.
Q. And it shows Mr. Mendoza being on an anti-anxiety medication in July of 2019, correct?
A. Yes.
Q. And that would be the Hydroxyzine?
A. Yes.

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Q. Were there other medications on this list that relate to anxiety?
A. Well, all of them can relate to anxiety except for the one on top. That's an allergy med.
Q. And then to return to the note from August 16th -- a little bit cumbersome, so bear with me.
So this is the progress note that you were looking at earlier from August 16th of 2019, correct?
A. That was the one that was shown to me earlier, yes.
Q. And I want to be clear, this is the note that you were referring to in your report when you talk about this incident on August 16th, correct?
A. I believe it is, yes.
Q. And I mean, the complaint that's stated in the first two lines is almost word for word your description of Mr. Mendoza's complaint on that date, correct?
A. Yes.
Q. So this note is what you were talking about in your report for this date, correct?
A. I believe so, yes.
Q. And, again, this is -- this was an R.N.,

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not an LPN, responding to Mr. Mendoza's complaint, correct?
A. Yes.
Q. And other than -- other than the pulse, his vitals were normal, correct?
A. Well, his respiratory rate is a little high, too.
Q. Well, how high?
A. Oh, I think top normal is sixteen.
Q. And this is somebody who was already on medication for anxiety, correct?
A. Well, you showed me -- you showed me the month previously. I don't know if he was on -- I would assume he was, but I haven't seen the spreadsheet for that month.
Q. Well, take a look at the page on the screen. This is from August of that year, correct?
A. Yes, all right. That's August, yes, he was.
Q. And he's on the Hydroxyzine in August of that year, correct?
A. Yes.
Q. So this was somebody who was already on medication prescribed by a provider for anxiety

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medications, correct?
A. Yes.
Q. So the R.N. didn't, quote, unquote, diagnose him with anxiety, correct?
A. Does not look like it.
Q. He had already been diagnosed with anxiety, correct?
MR. WEIL: Object to form.
THE WITNESS: I have not seen anything that showed where he had been diagnosed with anxiety. You haven't showed me anything like that.
Q. (BY MR. JONES:) Well, let my put it differently. He had already been prescribed an anti-anxiety medication, correct?
A. Yes.
Q. And those -- and you don't have any reason to believe that the anti-anxiety medication that he had already been taking in July and August hadn't been prescribed or authorized by a practitioner, do you?
A. No.
Q. And when Mr. Mendoza came to the nurse on the evening of August 16th, he reported to her that he had refused or declined to take the

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anti-anxiety medication earlier that day, correct?
A. Yes.
Q. And that he had been drinking a lot of coffee.
Do you see that?
A. Yes.
Q. I'm showing you a progress note from August 30th, correct?
A. Yes.
Q. And this is something you would have reviewed in your work on the case, correct?
A. Yes.
Q. And his vitals were fine on that day, correct?
A. Yes.
Q. No indication there that any sort of problem had developed because of the care he was given on August 16th, correct?
A. No.
Q. My statement was a correct one; is that true?
A. Your statement was a correct one.
Q. Okay. There's no evidence that you're aware of that there was an adverse outcome for Mr. Mendoza because of the care he was provided in

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the jail, correct?
A. Correct.
Q. Or that there was any treatment that he was seeking that he did not receive, correct?
A. Correct.
Q. I'm sorry, I didn't hear your answer.
A. Correct.
Q. If we could shift gears, and I'd like to ask you about Elizabeth Coleman.
You talked about with Mr. Knott the fact that she had had an incident on January 8th of 2020, that resulted in her being sent to the hospital, correct?
A. Yes.
Q. And she had fallen and hit her head, correct?
A. Yes.
Q. And there was a question on January 8th as to whether that had been caused by a seizure, correct?
A. Yes.
Q. And she did, in fact, go to the hospital, correct?
A. Yes.
Q. That was on the 8th?

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A. Yes.
Q. And the hospital, in discharging her, indicated that -- well, let me ask you: What does it mean in this set what I'm calling discharge paperwork from the hospital, that it describes, quote, unquote, your medication list?
What does that mean?
A. Well, I don't know if that means that it's medications that the patient came in on. I don't believe that she went to the hospital on those medications, but she might have, I guess.
Q. Well, let me ask you, do you know or do you not know whether -- when she went to the hospital, she was already on those medications?
A. Well, let's take the first one, copaxone. I don't believe she was on the medication copaxone when she went to the hospital.
Q. What's copaxone for?
A. It's a medicine for -- I believe it's a medicine for muscular (sic) sclerosis.
Q. What about the other ones?
A. I don't know what she was on when she went to the hospital. It might have been medications that they identified from their records from previous admissions to the hospital or from the

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pharmacy, from records they had.
Q. I'm sharing my screen again showing you MC Medical 11723 to 74. This is a medical history and health appraisal completed on January 8th, correct?
A. Yes.
Q. And under subjective data it indicates she's got MS, correct?
A. Yes.
Q. And that she has a history of seizures, yes?
A. Yes.
Q. And that she usually takes copaxone for her MS and seizures, correct?
A. Yes.
Q. So going back to the hospital discharge summary, or after-visit summary, those medications listed under her medication list, do you have any reason to believe those weren't medications that she had regularly been taking at that point?
A. No.
Q. And that's in particular given the medical history form, correct?
A. Yes.
Q. So then if we look at the progress note

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from January 10th, this is two days later in the jail, correct?
A. Yes.
Q. And so in your report you indicate that on January 10th Miss Coleman reported to the jail nurse that she had had a seizure, yes?
A. Yes.
Q. And, in fact, the progress note indicates that on January 10th that she stated to the nurse at the evening med pass, quote, did you hear what happened? I had a seizure. Couldn't feel my legs and fell and hit my head. See? End quote. Do you see that?
A. Yes.
Q. Given everything we've talked about, that is what had happened on the 8th, and your understanding of what happened on the 8th, isn't this, in fact, a note indicating that the patient was talking to the nurse about what had happened on -- two days earlier on January 8th?
A. Yes.
Q. And as a result of what happened on the 8th, she went to the hospital, yes?
A. Yes.
Q. So when you say in your report no workup

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was done, that's not correct, is it?
A. No workup was done at the hospital.
Q. And when you say the nurse practitioner didn't see Coleman either then or later for this complaint, in fact, Ms. Coleman had been seen at the hospital for that complaint, yes?
A. Yes.
Q. And we already talked about the fact that later on that month, Ms. Coleman was, in fact, seen by the nurse practitioner at the jail, correct?
A. Yes.
Q. And when you said that the nurse practitioner prescribed anti-seizure medication topiramate over the telephone, that prescription or direction to start that medication was consistent with what the hospital had indicated, correct?
A. Yes.
Q. And it was consistent based on reviewing all of these records with what Ms. Coleman had previously been taking, correct?
A. Yes.
Q. If we could take a look at Mr. Maske. So in your report, you talk about the situation on June 14th of 2019, correct, involving

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chest pain?
A. Yes.
Q. And what you say in your report is that the nurse practitioner ordered the nurse to give Mr. Maske the blood pressure medication clonidine. Do you see that?
A. Yes.
Q. What's lisinopril?
A. Lisinopril is a blood pressure medicine.
Q. Is it the same thing as clonidine?
A. No.
Q. Can you -- well, what's clonidine?
A. Clonidine is a medicine that is -- in the past was sometimes used for blood pressure. It is not used for blood pressure in the modern era because it doesn't last long enough. It's also sedating, so it's sometimes used as a sedative.
Q. What did you mean in your report when you referred to an emergency dose of clonidine?
A. Well, there is -- there is an old belief that if your blood pressure numbers got too high that you should be -- that patients would benefit by getting an emergency dose of clonidine to bring the blood pressure down emergently before it caused a

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stroke or heart attack or something like that. That is actually --

Q. So --

A. That is -- let me finish, please.

Q. I'm sorry.

A. That has actually been disproven, and it is not done much anymore. It is being done in this case. I've seen a couple of cases of it. But it is an -- when it is administered that way, as for a hypertensive urgency, it is an urgent or emergent medication. That's why you're giving it.

Q. So it's a one-time dose or a short-term dosage prescribed to see if it will reduce the blood pressure.

Is that what you're describing in your report described by an emergency dose of clonidine?

A. That is correct. It was given because Mr. Maske or Maske's blood pressure was felt to be too high so they gave a dose of clonidine in order to reduce it emergently on an emergency basis or an urgent basis.

Q. So I'm showing my screen again. Are you able to see it?

A. Yes.

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Q. Ms. Monroe, or MC Medical 37679, this is the progress note or series of notes from June 13th and 14th of 2019, correct?

A. Correct.

Q. And the notes from the 14th, those are what you were referring to when you were talking in your report about Mr. Maske having been seen for complaints of chest pain on the 14th, correct?

A. Right.

Q. And forgive me, you may have probably heard this, but it was a nurse, not an LPN, that saw him on the 14th for his complaint, correct?

A. Correct.

MR. WEIL: Object to form.

Go ahead.

Q. (BY MR. JONES:) So you were wrong in your report when you said that an LPN saw him, correct?

A. Correct.

Q. And the nurse took his vitals, looks like she listened to his heart, made her notes, and indicated that she would discuss with the nurse practitioner, correct?

A. Yes.

Q. And the nurse practitioner prescribed

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lisinopril, a course of lisinopril for a course of a hundred twenty days, correct?

A. Yes.

Q. And further checks of his blood pressure, correct?

A. Yes.

Q. There's no indication of an order for clonidine, is there?

A. No. I don't see an order for clonidine.

Q. So what were you referring to in your report when the basis for your opinion relating to this June 14th incident was that the nurse practitioner prescribed clonidine?

A. I don't know. It appears I made a mistake.

Q. So that portion of your report indicating that the nurse practitioner ordered the nurse to give clonidine is incorrect, yes?

A. It appears so.

Q. And if we look at the MAR for June of 2019 at 3767273, there's no indication that he was prescribed or given clonidine in June of 2019, correct?

A. Correct.

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Q. The other portion of your report relating to Mr. Maske refers to an incident on July 4th, correct?

A. Yes.

Q. And I'm showing you MC Medical 37765 and 66.

Do you see that on the screen?

A. Yes.

Q. And is this a -- is this the form or portion of the medical record referring to when -- with respect to until July 4th incident?

A. I believe so. He has abnormal vital signs.

Q. Okay. And so the officer, in interacting with Mr. Maske about his complaint, noted that Mr. Maske said the pain had been there a couple of hours since supper, correct?

A. Yes.

Q. And when asked what he subjectively believed was causing the pain, he indicated heartburn, yes?

A. Yes.

Q. And when asked if he had had similar symptoms before, he said all his life. It gets worse as he gets older referring presumably to what

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he had attributed to being heartburn, correct?
A. Correct.
Q. And the other symptoms he reported or indicated he didn't have are documented on the report, correct?
A. Yes.
Q. And including the officer's observation that Mr. Maske was burping?
A. Yes.
Q. And the directions here were to give -- to start a course of -- well, how do you say the medication, Doctor?
A. I can't -- I can't read -- I can't read it. You'll have to make it bigger. Omeprazole.
Q. That's a heartburn medication, yes?
A. Yes.
Q. Essentially Prilosec?
A. Yes.
Q. And I'm showing you a progress note from the next day, July 5th, correct?
A. Yes.
Q. 37664 is the Bates number. And this is the nurse talking to Mr. Maske, yes?

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A. Yes.
Q. And she was following up with him after his report of chest pain the night prior, yes?
A. I can't read it. You'll have to make it bigger.
Q. Is that better?
A. Yes.
Q. So she was following up with him about his report of chest pain, yes?
A. Yes.
Q. And he indicated to her that he had taken the Tums which had helped, yes?
A. Yes.
Q. And he reported to her that this usually occurs after he eats at night, yes?
A. Yes.
Q. And his request to her was simply that he get Tums in addition to the Omeprazole that he was already on, yes?
A. Yes.
Q. Any indication there of an ongoing problem as a result of what happened on July 4th?
A. No.
Q. And he was seen on July 6th, correct?
A. Yes.

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Q. And that subjectively he reported he was having increased acid reflux, yes?
A. Yes.
Q. And any problem with the vital signs that the nurse was indicating there?
A. No.
Q. So what he was reporting was that he was having acid reflux, yes?
A. Yes.
Q. Any sign of an ongoing problem that was cardiac in nature at this point?
A. No. There's no indication of cardiac at this point.
Q. And this is a progress note from July 19th, correct?
A. Yes.
Q. MC Medical 37653, and this is another follow up by the nurse relating to his earlier complaints from the 3rd, 4th, 5th, and 6th of heartburn?
A. Yes.
Q. And he's not reporting any further heartburn at this point, correct?
A. Yes.
Q. Any problems with the vitals on

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July 19th?
A. No.
Q. So from the records I've shown you from the 4th through the 19th, does it appear that Mr. Maske, during that period of time, was suffering from heartburn that resolved over time with the use of the equivalent of Prilosec?
A. Yes.
Q. Is there any indication from your review of those records, as we sit here now, that Mr. Maske had any sort of cardiac problem?
A. No.
Q. Let me ask you about Jessie Hanson. This was an individual who reported on March 17th that he was having abdominal pain, vomiting, and in some way blood in his sputum, correct?
A. Yes.
Q. And the directions by the provider at the jail was that he should be taken to the hospital, yes?
A. Yes.
Q. And that happened. He was sent to the hospital, correct?
A. Yes.

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Q. And I'm showing you, I've got up on the screen, the records from his time at the hospital.
Do you recognize those?
A. Yes.
Q. These are MC 20 -- Medical 23681 to 690.
You reviewed those in the course of your review of Mr. Hanson's situation, yes?
A. Yes.
Q. And on the second page of the document, and again, the symptoms were abdominal pain, vomiting, or coughing blood, yes?
A. Yes.
Q. And the note indicates that he should return to the emergency department if those symptoms worsen, correct?
A. Regarding your reported hemoptysis -- you'll have to raise it up -- if you find yourself incarcerated for longer than two weeks, ask for the jail medical staff to have you further evaluated with the jail physician and/or pulmonology.
There is -- there's another -- there's another form where it said to come back if you get worse. I'm in the sure where that was.
Q. What I'm actually referring to is just above there where it says: Follow-up instructions.

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Return to emergency department, and then under comments, if symptoms worsen, yes?
A. Yes. There's another page up there or, I believe, it adds more, but yes, that's what that one says.
Q. And later on it says this is in reference to hemoptysis. Get prompt medical attention. So when they say get prompt medical attention, that would be seek medical attention, yes?
A. Yes. Get prompt medical attention for coughing, fever, trouble breathing, chest pain, chest pressure, feeling weak, or fainting. Any of those.
Q. And so then on March 31st, you indicate -- you indicate in your report that he was suffering or complaining of chest pain, yes?
A. Yes.
Q. And those are the wrong documents sorry. So seek medical attention, if you have any complaint of chest discomfort or pain, yes?
A. Yes.
Q. And so then on the 31st, we're looking at the medical progress note of MC Medical 23616. He has a subjective complaint of chest pain, yes?

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A. Yes.
Q. And he's seen by the nurse, yes?
A. Yes.
Q. Not an LPN, as you indicate in your report, yes?
A. Yes.
Q. And she takes his vitals, yes, which are reported on the form?
A. Yes.
Q. Anything unusual or abnormal in those vitals?
A. His heart rate's low.
Q. Otherwise?
A. His blood pressure is a little high.
Q. Anything alarming in those vital signs?
A. No.
Q. And she indicates that -- well, I'm not sure what the first word is, but that his breathing is unlabored?
A. Yes.
Q. Got complaints of chest pain midsternum and no radiation and pulse is regular and strong, yes?
A. Yes.

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Q. And that he's nondiaphoretic?
A. Yes.
Q. Which means what?
A. He's not sweating.
Q. And she assesses it is possibly acid reflux, correct?
A. Yes.
Q. And the plan is to give him Tums and recheck later that day, yes?
A. Yes.
Q. And, I mean, prescribing Tums if you suspect acid reflex, that's a reasonable response, yes?
A. In this, yes. Although in this case, for a patient who had been to the ER, recently, comes in with complaints as referenced in the ER, seek medical attention if you have these, that patient should have been elevated to see a practitioner.
Q. And what is about the fact that he had had abdominal pain, vomiting, and coughing blood that means in particular he should go to the ER for chest pain over any other patient?
MR. WEIL: Object to form.
THE WITNESS: I don't understand that

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question.
Q. (BY MR. JONES:) Well, I guess what I'm asking about is his symptom on this date is some form of chest pain which was not his symptom that led him to go to the hospital two weeks earlier, correct?
A. Yes. Well, you're misunderstanding me. He needs to see a practitioner. So a practitioner could have gone to see him or he could have been sent out, but it would have been perfectly appropriate for a practitioner to see him --
Q. And again --
A. -- at the jail.
Q. It would be reasonable to give someone Tums if you suspected acid reflux, yes?
A. Yeah. I'm not criticizing that he got Tums. I'm criticizing the fact that he was not seen by a practitioner.
Q. And the nurse followed through and did recheck his vitals that afternoon, yes?
A. Yes.
Q. And the vitals were normal, yes?
A. Well, the heart rate is still a little low, but not significantly.
Q. Is there anything about the vitals that

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suggest a need for further follow-up care at that point when they were rechecked?
A. The vitals don't indicate a need for follow-up care, but the overall presentation of a patient that had been sick enough to go to the hospital recently was having similar symptoms that should have been elevated to see a practitioner.
Q. And to go back to my question, is there anything about the vitals as they were measured that afternoon that would have indicated the need for further follow-up care?
A. Well, they're not normal. So any time vital signs are not normal, they need to be checked again. So she rechecked them, that's great, because they weren't normal. These aren't normal. They need to be rechecked.
Q. Tell me what's not normal about the afternoon vital signs?
A. The heart rate is low.
Q. How low?
A. Normal goes down to sixty. So it's not very low, but it's still abnormal. So it should have been rechecked.
Q. And there were no other complaints by the patient when he was seen that afternoon, yes?

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A. I don't know. There's none recorded.
Q. Well, where it says no other complaints -- no other complaints by patient, yes?
A. I'm not seeing where you're pointing.
Q. Directly below the vital signs that afternoon.
A. I can't read it.
Q. Does that help?
A. No other complaints by patient. That's right.
So that to me indicates no other complaints other than the ones that she had documented above. I don't read that as meaning the complaints he had above are gone.
Q. Do you have any indication from your review of Mr. Hanson's six hundred and sixty-seven pages of medical records that there was any cardiac issue that he suffered from?
A. No.
Q. Any evidence from your review of these six hundred and sixty-six pages of medical records that there was any ongoing symptoms beyond the afternoon recheck on March 31st of 2017?
A. Not that I recall.
Q. And that any information that you have

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from your review of the chart that was any sort of adverse outcome for Mr. Hanson?
A. No.
Q. I'd like to ask you about Mr. Brush.
In particular, the interaction on February 22nd, 2020. I have up on the screen MC Medical 8396.
As far as you know, is this the interaction you were referring to in your report as being on February 20th?
A. Would you make it larger, please.
Q. Yup. Sorry.
Is that better?
A. I believe so, yes.
Q. This subjective complaint in terms of a skipping heartbeat or that he felt a skipping heartbeat, that's part of what was noted on this February 2nd, 2020, note, yes?
A. Yes.
Q. And there's no explicit mention by Mr. Brush of chest pain, right?
A. No. Just a quick, dull cramping.
Q. And the nurse did an objective assessment, yes?
A. Yes.

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Q. And there were no signs or symptoms of physical distress that she noted, yes?
A. Yes.
Q. And she listened to his heart?
A. Yes.
Q. And there were no skips, clicks, or murmurs that she could observe on listening to his heart, yes?
A. Yes.
Q. And he was educated or told by the nurse to follow if he had any worsening symptoms, correct?
A. Yes.
Q. And am I correct in understanding that you're not aware of any adverse outcome that resulted from Mr. Brush or rather for Mr. Brush from this intersection of Nurse Fennigkoh?
A. No.
Q. And are you aware, from your review of his entire medical record, whether or not he had any cardiac condition?
A. I'm not aware of any cardiac condition.
Q. And is there any indication in the medical records that he came back to the medical

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personnel to indicate that what he was feeling when he first made the complaint on the 22nd that he continued to feel those symptoms or that they got worse?
A. No.
Q. And Mr. Knott asked you about an incident on December 21st or the situation on December 21st. I believe you discussed this set of narrative notes with Mr. Knott, yes?
A. Yes.
Q. As being an MC Medical 8426.
And I want to be sure. I think he went over the details with you, but this page from Mr. Brush's medical records, that's the portion of the medical records you were referring to in your report when you discussed the interaction on December 21st, correct?
A. I believe so.
Q. Nicholas Hage, quickly.
MR. KNOTT: Hey, guys, I got to jump in here and say I've got to take off for the airport, so Daniel's going to cover for the end of the deposition for the record.
MR. JONES: Okay. Thanks, Doug.
Q. (BY MR. JONES:) Doctor, I've got up on

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the screen 22552, a progress note from March 19 of 2019.
I want to be certain, this is the progress note you were referring to in your report when you talked about an interaction on March 1st of that year, correct?
A. Yes.
Q. And, again, it wasn't an LPN, it was a nurse, correct?
A. Yes.
Q. And she did talk to the practitioner Dr. Schamber, correct?
A. Yes.
Q. And you're not aware of any information in Mr. Hage's medical record that indicates there was any sort of adverse outcome from this situation, correct?
A. Correct.
Q. You're not aware that he continued to complain of anything relating to this lump, correct?
A. Correct.
Q. I want to ask you about Jeremy Hodgkins. In your report you note that Mr. Hodgkins was booked to the jail on May 14th with a prescription for

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suboxone, a medicine used to treat dependents on opioids, correct?
A. Yes.
Q. And from your time in correctional medicine, are there any limits on which jails or which correctional facilities can prescribe or provide suboxone or is that something that any jail can provide?
A. Well, jails don't provide them. Practitioners provide them. And no, there's no -- there's no limit to who can prescribe suboxone.
At this point in time, you would have needed what's called -- you would have had to ask for permission to prescribe suboxone, but there's two ways to continue suboxone on someone who's been on it, and one way is to ask the outside provider who had been prescribing it to continue it and bring it to the jail and give it.
The second way is for the practitioner, which has since been removed, but in 2019 needed to have special training, and to give it in that -- to get that so you could prescribe it.
So the short answer is there were ways to continue suboxone in the jail, and it should have been continued in the jail. It was inappropriate to

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stop it.
Q. And you indicate in your report that in your opinion there was no treatment or care provided for opioid withdrawal or addiction, right?
A. That is correct.
Q. So I'm showing you the progress note from -- now I am.
Do you see my screen?
A. Yes.
Q. The progress note from May 14th, correct?
A. Could you increase it, please.
Q. Yup. Are you able to read it?
A. Yes.
Q. So there is an order signed off by -- well, I'm going to represent to you it was signed off by Lisa Pisney starting certain medications.
Do you see that, the handwriting portion?
A. Yes. Starting Hydroxyzine and dicyclomine. Neither of those are treatments for opiate withdrawal or oipioid dependency.
If you look at -- if you look at guidelines written by the American Addiction Society or the guidelines published by the Department of

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Justice, neither Hydroxyzine or dicyclomine are on there for treatments of opioid withdrawal or addiction?
Q. And what's your understanding from your review of the medical records as to why those were being prescribed at this point?
A. Well, I assume that they are being prescribed as a substitution for suboxone, but if that's the case, they are not treatments. They're not treatments for opioid withdrawal.
Q. Would they counteract any symptoms from oipioid withdrawal?
A. They might. But there -- but once again, if you look at the guidelines of opioid withdrawal, those are not listed. Hydroxyzine is not listed.
Q. I want to ask you about the patient you identify as Allen Dalton in your report on page 13. Am I -- this is not important, but just so we're talking about the right person, his name was actually Dalton Allen, correct?
A. Okay. Yes.
Q. And what you're talking about in your report is an interaction on June 12th of '21, about tooth pain, correct?

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A. Yes.
Q. And is this the -- I'm showing you a dental progress note.
Is this the record you were referring to?
A. It doesn't look familiar, and that is not -- no. I don't believe so. That took place on 8-21-18 not 6-12-21.
Q. I have the wrong one. Sorry. I've got the wrong number. Sorry. All right.
I'm going to set him aside for the moment. Mr. Crispin, Chase Crispin. There's two separate situations you're talking about with respect to Mr. Crispin, right? One on February 9th and one on September 15, 2019?
A. Yup.
Q. So taking the earlier one before, September 15 of 2017. Okay. Do you see my screen ends Monroe County 35869?
A. Yes.
Q. And this is the evaluation for dental pain on September 15 of 2017, correct?
A. Yes.
Q. And this is a complaint about three teeth on the lower right-hand side of his jaw

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correct?
Numbers 3031 and 32, yes?
A. Yes.
Q. And the -- the direction is to prescribe an antibiotic along with an oral rinse, right?
A. Yes.
Q. And then he had -- he was seen again on October 4th of 2017, and that's this progress note at Monroe County 36867, right?
A. Yes.
Q. And he's being seen here again for tooth pain?
A. Yes.
Q. He's seen -- being seen for different teeth on this day, correct?
A. Yes.
Q. Two teeth on the lower left-hand side of his jaw, seventeen and eighteen, correct?
A. Yes.
Q. So the visit or the evaluation on the 5th of September was teeth on the lower right-hand side, and the evaluation on October 4th was teeth on the lower left-hand side, correct?
A. Yes.
Q. Different teeth on those two occasions,

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yes?
A. Yes. But it doesn't change the fact that one, it's inappropriate to prescribe antibiotics without personally examining the patient. The practitioner should have seen the patient. And it's inappropriate to prescribe antibiotics for a dental abscess or a dental complication without sending the patient to see a dentist.
Q. Is there any indication in your review of the records, now that we see that these visits were for different teeth, that the antibiotics prescribed as a result of the September 5th of 2017, interaction doesn't resolve any infection that existed at that time?
A. I'm not sure what the question is. The fact that he had two -- that he had two dental infections within a month, one required that -- and especially when the second one is causing less --
Q. Doctor, if you're not sure what the question is, let me ask you a question so you understand what I'm asking.
Is there any indication in the medical record that the antibiotic prescribed as of September 5th didn't resolve any infection that

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existed for those teeth on the lower right side of his jaw at that time?
A. The nurse makes no mention of the teeth on the right side in this -- in this note.
Q. Do you have any other evidence from the file based on your review of this chart that any infection that existed on the lower right-hand side of his jaw as of September 5th of 2017, wasn't resolved by the antibiotics that were prescribed?
A. No.
Q. And do you have any indication, based on your review of his chart, that any infection that existed on the lower left-hand side of his jar as of October 4th of 2017, didn't resolve as a result of the antibiotics prescribed at that time?
A. No. There should have been a follow-up note if they weren't -- if the patient was not going to be referred to a dentist and was not going to be seen by a practitioner, would you think there would at least be a follow-up by somebody to see if the swollen jaw, the swollen left-sided facial swelling had resolved, but there is no note.
Q. Is there any indication in the chart that any infection that existed as of October 4th wasn't resolved by the antibiotic?

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A. No. There's no other -- the patient did not see a practitioner. I have seen no other charts from the nurse and was not sent to a dentist, so I have no documentation either way.
Q. Is there any indication in the chart that Mr. Crispin continued to complain of lower left-hand side jaw pain after being prescribed the antibiotic on October 4th?
A. No.
Q. Do you know whether or not Mr. Crispin had a history of ear infections?
A. No.
Q. If the chart indicates that he did, would you have any reason -- well, strike that.
From your review of the chart, you don't know whether or not he had a history of ear infections; is that correct?
A. I don't remember if he had a history of ear infections.
Q. Well, you didn't note it in your report, did you?
A. I didn't note it in my report.
Q. And as you sit here now, having prepared for the deposition and done all the work that you've done in the case, do you have any knowledge as to

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whether or not he had a history of ear infections?
A. No. I don't remember if he did or not.
Q. If we look at the chart from February 9th, which is one of the dates you refer to in your report, this is a situation where Mr. Crispin was seen by an LPN who then called the provider, correct?
A. Yes.
Q. And the provider identified the plan that would be followed, correct, not the LPN?
A. Yes. That's what I said. She called the practitioner who prescribed an antibiotic.
Q. But in this case, it would not be correct to say that the LPN identified the plan of treatment, correct?
A. No. But the LPN wrote a diagnosis right otitis media.
Q. She wrote assessment, correct?
A. That's a diagnosis.
Q. Okay. And she discussed that with the provider, and the provider directed or ordered a plan of treatment, correct?
A. Correct.
Q. If one antibiotic fails to resolve a

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possible infection, how common or uncommon is it for the practitioner to order a new or different antibiotic?

A. Without ever seeing the patient in the free world -- I mean, the outside of the jail, that doesn't happen. So it is not uncommon to order two courses of antibiotics.

What is uncommon is not to have seen the patient that you're ordering them for either time.

Q. And Mr. Crispin was seen again on February 19th and prescribed a new antibiotic.

Did you have any information as to whether or not that new antibiotic resolved the infection?

A. No, I have no follow-up documentation of any kind.

Q. You're not able -- you're not opining that Mr. Crispin had an adverse outcome, correct?

A. Correct.

Q. And with respect to Ms. Oliver, Erin Oliver, am I correct in understanding that you don't know when the first time was that medical staff at the jail contacted the dentist relating to Ms. Oliver, correct?

A. No.

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Q. And you don't know how long it took medical staff at the jail to obtain an appointment for Ms. Oliver to be seen, correct?

A. No. And I don't know how hard they tried either.

Q. You just don't --

A. No. When I work with dentists and I say it's an urgent situation and I need them to be seen now, they get seen now.

Q. And you don't have any knowledge about the availability of dentists in the Sparta area at the point in time that Oliver was in the jail, do you?

A. No.

MR. WEIL: Object to form.

Q. (BY MR. JONES:) I'm sorry, I didn't hear your answer.

A. No.

Q. With respect to Mr. Schmieder, if I understand correctly, you, as part of your review, looked at the report or investigation materials that were prepared by the Monroe County Sheriff's Department after Mr. Schmieder died, correct?

A. Yes.

Q. Did you also review the report prepared

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by the Lacrosse County Sheriff's Department regarding Mr. Schmieder's death?

A. That is not something I recall seeing.

Q. Well, it was among the materials that you received or indicate that you reviewed as part of preparing your report.

A. Well, that probably -- I probably did. I'd have to pull it up.

Do you want me to --

Q. Okay. So if Monroe County referred Mr. Schmieder's death to the Lacrosse County Sheriff's Department to conduct a follow-on investigation, it's not accurate to say that the county didn't do any further investigation, is it?

A. Well, I would -- I believe that I meant by that any further investigation than that that was -- that I had reviewed. But I reviewed everything in the file that was sent to me, and I guess I lumped them both together. No review was done after that.

Q. Well, you refer specifically in your report to a county investigator having conducted interviews. But you don't refer to an outside investigator, that is, the Lacrosse County Sheriff's Department.

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So let me ask again to be clear, when you said in your report that it doesn't appear that the county did any further investigation, were you referring to the county not going on its own investigation, or are you actually saying that the county didn't do an investigation other than the two that were conducted?

A. Other than the two that were conducted.

Q. And so in reviewing the records of the Lacrosse County investigation, did you make any note of what the health care provider or nurse who was interviewed said about what had happened that evening?

A. I don't recall reading that, no.

Q. And it's not in your report, is it?

A. No.

Q. And so as you sit here now, having prepared for your deposition, are you in a position to say what it is that the nurse said happened that evening?

A. I don't recall reading what the nurse said happened that evening.

Q. And if the nurse had indicated that -- I'm sorry. Hold on.

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By the way, what's a Combivent inhaler?

A. A Combivent inhaler is a combination of a low-dose steroid and a long-acting bronchodilater.

Q. So if that Mr. Schmieder had been using in the jail a Combivent inhaler, would that indicate that he was not refused the steroid inhaler?

A. That's different than a mometisone inhaler. A mometisone inhaler is high dose. So it's different.

Q. It's different, but it is still, in part, a steroid inhaler?

A. It is a low-dose steroid inhaler, yes.

Q. And that would have to be prescribed by a provider?

A. Yes.

Q. So if Mr. Schmieder had been using a Combivent inhaler in the jail, that would be him using a low-dose steroid inhaler prescribed by a provider, yes?

A. Right. That isn't the issue. I had no problem with him continuing the Combivent inhaler. That was a good call. I don't -- I don't understand why the mometisone inhaler was discontinued, and I

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don't understand why if you're going to discontinue the mometisone inhaler, why you didn't -- why no practitioner came in and talked to him or did an evaluation. That's -- that's what I don't understand, and I don't agree with.

So a practitioner at a jail can do anything he or she wants with the medications. They're the practitioners of the patient. That's their patient. But usually you make changes in a medication regimen after you've examined the patient.

Q. If the nurse indicated that on the evening before he died Mr. Schmieder had refused his Combivent inhaler, you don't have any reason to dispute that's, in fact, what occurred, do you?

A. No.

Q. So someone going to see if he would take his Combivent inhaler and him refusing, would you characterize that as nursing staff being aware of a problem and doing nothing to intervene?

A. Well, you make a good point that if a -- I don't believe that going and saying do you want your -- if you get a report that someone is in a serious medical problem, and you go and say do you want your medication and they say no or don't

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answer, and that's the only intervention, then that isn't enough, no.

Q. Okay. But let's --

A. An appropriate intervention would be actually go and see the patient, listen to their lungs, get a set of vital signs.

Q. You don't have any reason to dispute that Mr. Schmieder refused that inhaler the night before he passed away, correct?

A. I don't have any reason to dispute that. It sounds like a med pass encounter. The nurse came by with med pass, and he said: I don't want my meds. That's not the same as doing an evaluation of a patient that you have heard is having a lot of problems.

Q. When you said -- and you said it a couple times now -- that, quote, unquote, the nurse heard he was having a problem, am I right in understanding that's based entirely on the investigator's conversations with other inmates in the cell block or housing unit?

A. Yes.

Q. And so you're only going off of what those inmates were reported to have said to the investigator, correct?

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A. Yes.

Q. Outside of that, do you have any information from the records you reviewed relating to Mr. Schmieder that, one, he had trouble breathing that evening; or, two, that medical staff were informed of that?

A. That is the source of my statement that medical staff were informed. I have no other sources other than that.

Q. And if a patient that has been prescribed this inhaler declines to take it or use the inhaler, and indicates that he's fine without it that evening, is it your testimony that the medical practitioner should still insist on some sort of follow up with the patient?

A. We're talking about the patient had been there a month, Mr. Schmieder had been there a month, I believe, before he died.

Q. We're talking about Mr. Schmieder.

A. Yeah. I think he had been there a month, and the practitioner had never seen him.

Q. Let me focus in on the specific question.

If Mr. Schmieder indicated to medical personnel that he was refusing his inhaler that

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evening, and that he was fine that evening without it, is it your testimony that medical staff should have insisted on follow-up -- further follow-up at that point?

A. So you've described a scenario that hasn't -- that wasn't described in the documents I reviewed. I read no statements by the nurse that said Mr. Schmieder said: I'm fine. And, in fact, a lot of times when patients quote, unquote, refuse their medications, it's because they're asleep and they didn't hear the call, or they're on the phone, or they're on the -- they're in the bathroom, or they're just cranky, or whatever.

So I don't know any circumstances. I don't know if the nurse actually talked to him or if they have announced med pass and he didn't get up to go or any of that. So I don't know the circumstances.

I certainly don't know that he said I feel great and I don't think I need my meds tonight.

Q. So if the nurse stated to an investigator that Mr. Schmieder refused the Combivent inhaler saying he had his Albuterol with him and was fine, is it your testimony that the

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nurse should have insisted on further follow-up?

A. No.

Q. And you have no reason to dispute that was, in fact, what occurred, am I correct?

A. Correct.

Q. And in your report, when you say that he was not sent to the hospital despite other inmates reporting that his medical condition was, quote, unquote, deteriorating, again, that's based on the investigator's notes of what those other inmates said to him, correct?

A. Correct.

Q. There's no other source for that statement in your report, correct?

A. Yes.

Q. The patients you reviewed from the Monroe County Jail, those patients for the health care spans the six-year period, correct? 2016 to 2021, yes?

A. Yes.

Q. And those, again, those were all patients --

MR. WEIL: Object to form.

Q. (BY MR. JONES:) Those were patients' charts that were selected for you to review by

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plaintiff's counsel, correct?

A. Well, not entirely, but some.

Q. Well, which of the eleven or twelve patients that we discussed today that you discussed with Mr. Knott were not chosen for you to review by Mr. Weil or his firm?

A. The patients were all chosen. Some of the incidents that I came up with were not flagged or anything like that.

Q. So Mr. Weil chose the patients that you would review, or his firm did, correct?

A. They chose -- they flagged the files that I -- that I should review the charts. The files that were in the Fourth Amended Complaint were ones that I reviewed, and then I had the spreadsheet that they sent me, so I picked them out of that.

Q. Mr. Weil gave you a group of patient charts to review that he or his firm had selected, correct?

A. Yes.

Q. And then of those, you decided to discuss a certain subset in your report, correct?

A. Yes.

Q. And the ones you didn't discuss are ones either that you felt the care was appropriate or you

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couldn't assess one way or the other because of technical issues, yes?

A. Yes.

Q. And you don't know the criteria used to select the patient charts that were given to you, do you?

A. No. I do. They -- they came from the spreadsheet and evaluation -- of which ones potentially had problematic care.

Q. You don't know how those patients were chosen among the patient population, correct?

A. I'm not sure what you're asking. I think I understand how they were chosen. The patient charts were reviewed. A bunch of patients were eliminated because the care was appropriate. A subset of those who were left were given to me to review.

Q. But you don't know who or how those patients -- who identified those patients as being potentially inappropriate in terms of the care or who did that selection, do you?

A. I don't know the person who did that.

Q. Or how they decided that those were the patients with inappropriate care that you should review, correct?

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A. Well, I assume that they -- actually, I know -- I think that the person did look through the charts and the ones that that person thought potentially inappropriate care were referred to me.

Q. And you do not know the number of bookings in the Monroe County Jail during those six years, do you?

A. No.

Q. You do agree, though, that no matter the number of bookings, the number of charts you reviewed is not a statistically significant percentage of those bookings, correct?

MR. WEIL: Object to form.

Go ahead.

THE WITNESS: I was not -- I'm sorry. I was not trying to do a significantly significant sampling. That wasn't what I was attempting to do.

Q. (BY MR. JONES:) And you believe you saw a certain pattern in the eleven or twelve patient charts that you reviewed from the Monroe County Jail, yes?

A. Yes.

Q. In terms of the care that was being

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provided, yes?

A. I was looking at the way that medical was set up, and the way that medical is set up in Monroe County Jail was something that is different than most of the jails that I have ever seen, and I've seen a lot of them, where correctional officers were being asked to function essentially as nurses, where practitioners were doing assessments and prescriptions by telephone without ever seeing the patient. And that's -- that's the pattern that I saw.

Q. So you saw a pattern among those patient charts, correct?

A. Yes.

Q. But you would agree with me that it's not scientifically valid to draw conclusions about the care being provided to the entire patient population for those six years based on your review of those eleven or twelve charts, wouldn't you?

MR. WEIL: Object to form.

THE WITNESS: I am not saying that all the medical care in the Monroe County Jail was inappropriate and wrong. I'm not saying that. And I'm not saying that the practitioners were incompetent or uncaring.

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What I am saying is that Monroe County has an unusual system that is used by ACH which is incongruent with the standard of care which is how medical is standardly done outside of jails.

So in other words, I'm in a medical clinic or an urgent care center, I don't send a security guard in to take a patient's history and vital signs and then call me on the phone while I'm at home and tell me what's going on with this patient that showed up at the urgent care center. That never happens on the outside.

So that is an unusual thing. It's an unusual thing that practitioners are doing their entire evaluation, not that they're giving voice orders, but that they're doing their whole evaluation, prescribing, and then never following up, never seeing the patient. That is unusual, and that's different than is done on the outside, and it's different, frankly, than is done in most of the other jails that I'm familiar with, including my own.

Q. I guess what I'm trying to understand, Doctor, is whether, based on reviewing, I should have counted -- I'm not sure as I'm sitting here whether it's eleven or twelve, say twelve -- what

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I'm trying to understand is from reviewing twelve charts, whether you feel you have a medically sound or scientific basis to draw conclusions about all of the other charts that you didn't review from those six years.

MR. WEIL: Object to norm.

THE WITNESS: I think what I did learn from the charts that I did review is that the system that's set up by ACH in Monroe County is certainly different than is done on the outside. No medical care in any medical clinic on the outside is done that way in the ways that I've described. It's not done that way in most jails that I'm familiar with.

And I believe that if I reviewed every single chart, hundreds of charts, I would find the same system.

I also think I went in with the prejudice that -- that a -- just as one example, that a practitioner who doesn't see the patient that just practices on the phone, that gets a call, makes a diagnosis, makes a prescription, and then never follows up, never sees the patient, would be not as good, would be more likely to make mistakes than a practitioner who practiced in the way that is commonly done on the outside.

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I myself would not be as good if I just handled everything by phone and never actually talked to a patient, to the patients I was prescribing to.

So I identified that as being outside of the medical norm, outside of medical standard for medical practice. I believe that there's a pattern of not -- not accelerating appropriately. And so, I didn't intend to do a statistical analysis. I had with those eleven charts. I think I know how medical is run at the jail. And I identified how that was different than how it was run in -- normally run in medical settings.

Q. You're not in a position to say, are you, whether there were mistakes made in the care of any of the patients for whom you didn't review their charts, are you?

A. No.

Q. You're not in a position to say whether or not there were bad outcomes for patients other than those whose charts you reviewed, are you?

A. No.

Q. Just a couple of other things I want to follow up with you on, Doctor. I know we're getting late in the day.

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When you talk about the CQI program at the jail in your report, you talk about, quote, unquote, true CQI systems, and where we would go to know or understand what a true CQI system is? What's your source?

A. The best -- well, maybe the best source, but there are others, but the National Commission on Correctional Health Care Standards for Jails. The American Correctional Association Standards for Jails, both of those, either of them.

Q. And CQI, a good CQI system does look at data, correct?

A. Yes.

Q. I mean, it's a -- CQI does include the review and analysis of data, yes?

A. Broadly, yes.

Q. On a monthly or quarterly basis, yes?

A. Well, as I said, CQI isn't just statistics, so reviewing statistics, this is how many patients were seen in clinic, this is how many patients put in medical requests, that is not CQI. Not to say it's not important, it is, but it's not CQI.

Q. Does a component of true CQI incorporate activities to monitor quality of the health care

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service delivery including the review and analysis of monthly data?

A. Well, sure. Are you -- you analyze monthly data, but let's -- let's -- we're using terms. Let's say continuous -- CQI stands for continuous quality improvement.

So analyzing data does not -- does not -- is no -- is not continuous quality improvement. To get continuous quality improvement, you have to identify areas that need to be improved, so you can't improve an area that you haven't identified.

So you have to identify areas that need to be improved, and you can use statistics to do that. Then you have to make a plan to improve the place that you think needs to be improved, so you have to first find areas of deficiency or things that you could do better, and then you have to make a plan to improve it, and then you need to implement the plan, and then you need to at some point in the future evaluate the plan and see how it was doing.

That's CQI, those four steps. Having -- just looking at statistics, is none of those unless it's part of identifying a problem we have. I've looked at these statistics and we have --

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Q. What's the shorthand --

A. I've looked at these statistics and we have this problem, so that's the first step of CQI is identifying the problem and then developing a plan to fix it. Just looking at statistics without using it to develop -- to improve, is not part of CQI.

Q. What's the shorthand, the four elements or steps of CQI that you just referred to, or what are those four steps?

A. You mean identify a problem, make a plan to improve, implement the plan, and then evaluate how the plan works?

Q. Yes. That's what I was asking.

A. And then a fifth step would be change your operating procedure to implement the improvement that you've just made continuously, so there's the continuous quality improvement, and then do another one, start another one.

Q. Mr. Knott asked you which of the patients you reviewed for Monroe County were sentinel events, and I believe you identified Xiong and Oliver; is that correct?

A. Xiong.

Q. And Schmieder?

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A. Xiong and Mrs. Boyer. That would have been another one.

Q. Okay. Setting aside Mrs. Boyer, of the patient charts from Monroe County that you reviewed, were there any others that constituted sentinel events, as you used the term in your report, other than Mr. Schmieder, Mr. Xiong, and Ms. Oliver?

A. Of the charts that I reviewed, no others. But I know, just based on the size of the jail, that there were others. So anybody that went to the hospital unexpectedly, and I'm sure that there are patients who were -- and I know that there have been patients that were sent to the hospital -- many patients that were sent to the hospital appropriately. If any of those were unexpected, that's a sentinel event.

So there are other sentinel events, so of all the patients that were sent to the hospital, if those were unexpected and there was something that could have been done to prevent that, that's a sentinel event. So there are other sentinel events.

Q. I think my question to you, Doctor, was: Of the patients you reviewed, other than Ms. Boyer, which of them were sentinel events as you use the

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term? Are there any others besides Mr. Schmieder, Mr. Xiong, and Ms. Oliver?

A. Ms. Coleman falling off a bunk and hitting her head could be a sentinel event. That's on the borderline. Of the others, no, I don't believe so.

Q. And so Mr. Xiong, what made him or his situation a sentinel event?

A. The fact that he went unexpectedly to the hospital with cardiac disease. I'm going to assume that I'm right and that he did have a heart attack, but let's say even if he didn't, patient that was sent unexpectedly to the hospital because of fear of a heart attack, that would be -- that could be a sentinel event.

Q. And Ms. Oliver, what made her situation a sentinel event?

A. The fact that she had a whole bunch of teeth extracted. And it might be that nothing could have been done at the jail to have improved that, but the fact that she had -- she was sent out, and had unexpected surgery, I don't think that the jail expected her to have four teeth pulled; but the fact that that was done, that's a sentinel event.

Q. And so from the patients that you

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reviewed, the charts you reviewed that were not sentinel events, how would a proper or true CQI system, to use your terminology, have identified those patients as needing some sort of review or evaluation?

A. That's something for the jail to determine. So the jail and the jail medical staff, they are the ones that make that determination.

So the first thing is identifying that we have a problem in this regard. And no jail program is perfect. None. So all jail programs can be improved. So the Monroe County Jail is the one to identify what is our problem -- what is the problem that we have, or potential problem? How can we improve it?

So the jail would be in a much better situation than I am to identify their own problems.

Q. Well, so if the CQI program properly set up and administered would have flagged Mr. Xiong's case and Ms. Oliver's case or after-the-fact review, that's what you're saying, right?

A. Well, sentinel events is part of CQI, but that isn't what -- I didn't think what we were talking about. I thought we were talking about

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outcome studies where you identify that you have a problem, you evaluate the problem, you make a plan to improve the problem, and then you follow up with the plan.

So something that I would identify is the whole thing of practitioners practicing -- let's say prescribing medications over the phone and never following up. So is that a problem? I think it is. So a CQI would look into that. How often does that happen? Then you would sit around a table and say: Is it a problem? Can we improve it? What are we going to do to improve it, make a plan.

After you've done it for three months, say you evaluate the plan, and say: Are we better or are we not? Should we go back to the way it was before? So that would be one. There are others. I mean, I didn't really look at diabetics.

Q. So, Doctor, my question, as I had phrased it, was simply if Schmieder, Xiong, and Oliver were sentinel events, then my understanding of your opinion is that those would have been called out for after-the-fact review by a proper CQI program.

So far so good.

A. Evaluation of deaths and sentinel events

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is a proper event of CQI.

Q. So what I want to ask you about is: The other patients that you reviewed who were not sentinel events did not occur, are you saying that those other cases would have been called out or had fallen out for further after-the-fact review by a proper CQI program?

A. Sure. Yes. So --

Q. Let me ask you that. Let me ask you how is it that those cases would have fallen out for after-the-fact review by virtue of a true CQI program?

A. Okay. Well, I think we're talking about sentinel events. So, one, we have --

Q. No, no, no. We are not talking about sentinel events. I'm asking about the patients who were not sentinel events.

How would they have fallen out for further after-the-fact review by virtue of a CQI program?

A. Because the jail would have looked into it beforehand and identified problems. So one problem that you yourself identified, we have a problem getting patients in to a dentist. That's our problem. So I've identified a problem. Why are

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we --

Q. You're talking about Ms. Oliver now, correct?

A. Ms. Oliver's not the only one.

But you asked me to identify something that you could use -- that you could use as a trigger for CQI out of these patients that I've identified. That's one.

We have a problem getting patients in to dentists. That's our problem. So one, how often -- how often -- what is the scope of the problem? How many patients do we refer to dentists? What's the average length of time from the time of the referral until they get in to a dentist? What's the reason why we -- dentists give for not wanting to work with us, or whatever?

You define the problem. How do we fix the problem? Do we hire a dentist to come to the jail? That's what a lot of jails do. They hire a dentist come to the jail once in a week. Do we sign a contract with an outside dentist that gives us, say, five dental slots a week? How do we fix the problem? You try to fix it so that if you're asking about one thing that can -- that this could pop up, there's one.

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Q. Would a CQI program have flagged those other cases, the non-sentinel events for follow-up?

A. Maybe. It depends on what CQI you had done beforehand. I mean, it depends on what you're studying, so if you were studying -- we talked about people who are complaining of chest pain and are being given Tums, that would be -- that would be an appropriate topic for CQI. What is our Tums policy? What's our policy for people who complain of chest pain and gastric reflux? How do we handle those? Are we handling it appropriate?

It might be that your CQI program says yes, everything is hunky dory and appropriate with how we distribute Tums. Most of the time you can say we can make this better, and you do.

Q. So it's possible if the CQI program was looking at a particular problem or scenario, that one or more of those patients that fell under that scenario would fall out through the CQI program.

So far so good?

A. Right. You can pick anybody you want. You can pick any problem you want.

Q. But it's not necessarily true that those patients would have fallen out just by virtue of

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there being a, quote, unquote, true CQI program in the jail, correct?

A. No. You could have a true CQI program, and you chose to study other stuff that had nothing to do with any of these patients. You looked at diabetes. You looked at foot care. You looked at people who injured their ankles playing basketball. And you just never looked at anything related to the patients here.

But that's something that the jail and the medical staff choose. If you choose not to look at something, then it doesn't get looked at. But you could choose to look at something relating to these patients.

Q. Let me shift gears quickly to ask you about the portion of your report relating to staffing on pages 6 through 7.

You talk there about individuals with nontrivial complaints needing to be evaluated and examined by a practitioner, correct?

A. Yes.

Q. And so can you define for me any more specifically the line between trivial and nontrivial?

A. No. That's a common sense -- I guess

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common sensical thing. So you can pick examples that are definitely trivial. I have a hangnail. I have a minor rash on my foot.

You can pick examples that are clearly nontrivial. I'm throwing up blood.

And then there's a bunch of things that are kind of in the middle.

Q. And for the stuff that's in the middle, does that involve some degree of medical professional judgment as to whether it's trivial or not trivial?

MR. WEIL: Object to form.

THE WITNESS: Sure. But in a jail, almost everybody should be seen by a practitioner.

Q. (BY MR. JONES:) Well, you use the dividing line in your report between trivial and nontrivial, which is why I'm asking you if you could define it?

A. No. I'm not saying that nontrivial things should never been seen by a practitioner. And to a shorter answer, no, I can't actually define what trivial and nontrivial is. You are right that it requires judgment and protocols --

Q. And so when you -- when you talk on page --

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MR. WEIL: Can you let Dr. Keller finish his answer?

Q. (BY MR. JONES:) Oh, I'm sorry, Doctor. Were you finished? I didn't meant to cut you off.

A. I want to say that patients make that determination when you put in medical requests. They're saying when a patient comes to an urgent care clinic and walks in the door and says I'm here, they themselves have elevated their complaint to nontrivial.

And that's the same thing in a jail when a patient puts in a request for medical care, those pretty much all should be seen by a practitioner. The patient has requested medical care and the only way that it's not going to be seen by a practitioner is that if there's a well-developed process for specific items that are -- that can be -- that can be solved in some other way.

Q. Well, I'm sorry, I'm interrupting you again.

A. Well, for example, dandruff. I have dandruff, and all I want is a dandruff shampoo. So if there is a mechanism for that patient to get an over-the-counter dandruff shampoo without a practitioner, that's fine. And there are lots of

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such things.

But most people that -- most patients who put in a request, I want to be seen for whatever, back pain, heartburn, knee pain, headaches, I have a history of seizures, all of those should be seen by a practitioner just as they would in a community.

Q. Well, in your report you talk about at the bottom of page 6 that when a patient complains of a nontrivial complaint such as chest pain in a correctional facility, they should be evaluated in the same way, meaning by a practitioner.

And you go on to say all such patients, in other words, those who complain of a nontrivial complaint, should be evaluated and examined by a medical practitioner. That's your opinion, yes?

A. Yes.

Q. Am I fair in understanding that in making that point you were saying that patients in a jail with nontrivial complaints should be evaluated and examined by a practitioner?

A. What I -- yeah. What I am saying is that patients who request to see -- request medical care in a jail should be seen by a practitioner just like they would in a community.

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Could we -- could we continue this in a second? Could we take a short break?

MR. JONES: That's fine with me. I don't have but a couple minutes more, but I'm happy to take a break.

Why don't we take two or three minutes, take five minutes, and then I'll wrap up.

(A brief recess was had.)

Q. (BY MR. JONES:) Doctor, is it your opinion that any inmate or patient in a county jail who makes a medical complaint needs to be evaluated by a practitioner?

A. Most of them, and if they're not seen by a practitioner, there has to be defined guidelines for why not and what -- what -- exactly how that happens if they're not. The default should be that they're all seeing a practitioner.

Q. And is the dividing line the line that you identify in your report that is between those with trivial complaints and those with nontrivial complaints?

A. There's no good way to define that, and I think patients define it themselves so any patient that says I want to see -- I want medical care, the default should be they see a practitioner just

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like --
Q. So --
A. -- just like they would in a community.
Q. So your opinion is, in fact, that if an inmate complains of some sort of medical symptom or problem, seeking medical attention, that that individual has to be seen by a practitioner in order to satisfy the standard of care.
MR. WEIL: Object to form.
THE WITNESS: In most cases, yes. What should happen in a jail is the same as what happens in a community.
Q. (BY MR. JONES:) And what category of cases is it that an individual in custody in a jail asking for medical attention for some problem doesn't need to be seen by a practitioner?
A. Okay. Any case in which there is a prescription of a legacy drug, and a legacy is just something that needs to be prescribed by a practitioner. It cannot be -- it's illegal to -- you have to get it from a pharmacy.
Any encounter that involves a legacy drug, the patient needs to be seen by a practitioner. That's one.

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Any encounter that can be handled with over-the-counter medications, so that in the community a patient would not need to see a practitioner but just go to the corner drugstore and get it, in a jail you can't go to the corner drugstore and get it so sometimes you have to go to medical to get over-the-counter medications.
Many of those do not have to see a practitioner. Those cases need to be well defined. Who doesn't need to see a practitioner, what happens when they make a complaint, how it's handled, but those don't necessarily have to see a practitioner.
Q. I'm sorry, for the legacy prescriptions those do or don't have to see a practitioner?
A. You do. Just like if you want to get a blood pressure medication in the community, you have to see a practitioner.
Q. So if it's not a situation where the individual's complaint can be treated or resolved by an over-the-counter medication, the individual in a jail has to be seen by a practitioner in order to satisfy the standard of care.
Is that your opinion?
A. Just as it is in the community.

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Q. So is that a yes, Doctor?
A. Yes. In the community you cannot get a legacy drug without being seen by a practitioner, and that's the way it should be in a jail as well.
Q. Okay. So but what I'm trying to define with you is the categories where it's not necessary for an inmate in the jail complaining of a medical problem to be seen physically by a practitioner. And so far, I believe what you've identified for me is in certain circumstances where the situation can be resolved by an over-the-counter medication.
So far so good?
A. Right.
Q. Are there any other circumstances where an inmate's making a complaint seeking medical care, that the inmate does not have to be seen by a practitioner in order to satisfy the standard of care as you see it?
A. Well, if the patient doesn't want to see a practitioner, if the patient doesn't need a legacy drug and is happy getting -- their problem can be answered via -- via nursing protocols where a nurse can take care of it, or deputies for that matter, then no, they don't have to see a practitioner just like they don't in the community.

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Q. So the instances where an individual in a jail seeking medical care would not need to be seen by a practitioner in order to satisfy the standard of care, includes circumstances where the problem can be resolved with an over-the-counter medication, if the inmate refuses further medical care, and if the situation can be resolved by a nurse.
So far so good?
A. Well, no. I mean, I wouldn't really agree with that summary. I mean, this is -- this is -- if an inmate refuses medical care, that's a whole -- another subject. Inmates have the right to refuse medical care, but there's a lot of potholes that you can sprain your ankle in in that road, and we don't have to go through that. But if they're refusing medical care, then they're not seeking medical care.
If there are some instances where some patients still need to be seen by a medical practitioner, it depends on why they're refusing medical care. If an -- if the patient wants something that a nurse can give them, for example, will you -- I'm having -- because of mobility issues I'm having trouble clipping my toenails, if there's

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a service that a nurse can do that doesn't involve a prescription drug, that would be an example of something that can be handled by a nurse without recourse to a practitioner.

Q. So other than where the medical issue at question can be resolved with an over-the-counter drug or is something that a nurse can resolve, are there any other circumstances in your opinion where an inmate complaining of a medical problem seeking medical attention does not have to be seen by a practitioner in order to satisfy the standard of care?

A. Well, I can't think of any at this time.

Q. And ultimately, it's an issue of medical judgment as to whether an inmate who's complaining of a medical problem needs to be seen by a practitioner; is that correct?

A. To some degree it is. Any time there's a prescription of a legacy drug, and that includes reauthorizing medicines that they came in with, any time that that practitioner prescribes medications, they have to be -- the patient should be seen by the practitioner.

Q. In terms of your opinions about the

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training, orientation training provided by ACH, am I correct that any training that you're basing that opinion upon is listed among the materials that you reviewed on pages 2 and 3 of your report?

A. I don't understand that question.

Q. So in your report you list the materials that you considered in forming your opinions in this case, correct?

A. Yes.

Q. And is that a complete list of the materials you reviewed and considered in forming your opinions in this case?

A. I believe so.

Q. And so if you have opinions about orientation training provided by ACH, the basis -- the evidentiary basis for those opinions, that's found among the documents listed in those you considered in your report, correct?

A. Yes. There may -- ACH may have other training materials that I have not reviewed, and if I have not reviewed them, then I did consider them.

Q. The only ones you reviewed you've listed in your report?

A. Yes.

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Q. Your invoice in the case shows that you have about forty hours in on the file up until the date of your report, February 7th.

Do you recall that?

A. Yes.

Q. And roughly, are you able to portion those forty hours between the time you spent reviewing records and other materials to form your opinions and the portion of the forty hours that you spent drafting your report?

A. I don't think so, no.

Q. Do you have any records that would help you divide the forty hours among record review versus report writing?

A. I don't think so.

Q. Do you know when you started writing the report in this case?

A. I don't know, off the top of my head. I have would have to -- I'd have to go back and look.

Q. What would you look at?

A. I would look at my computer and see when the first -- when I started working on the document.

Q. Very quickly, under Dalton Allen -- I'm

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sharing my screen.

Can you see it?

A. You have to make it bigger.

Q. Sorry. Better?

A. Yes.

Q. I'm showing you what's marked as Monroe County 36380 through 36384, which is titled medical history and health appraisal.

Do you see that?

A. Yes.

Q. From March 19th of 2021, correct?

A. Yes.

Q. Do you recognize this as a document you reviewed in considering the care given to Mr. Allen?

A. I believe so, yes.

Q. And this looks like some sort of history and physical, right?

A. Yes.

Q. And it notes on page 4 of 5, so 36383, it includes notes about his -- a dental screening, correct?

A. Yes.

Q. And it -- it refers to the fact that he had upper dentures, his own teeth, and his lower jaw

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with two broken teeth, correct?
A. Yes.
Q. And this is as of March of 2021, yes?
A. Yes.
Q. And it goes on to say that what he wanted was denture glue, but he did not want to be referred to anyone, correct?
A. Yes.
Q. Is it fair to read that as saying he didn't want to be referred out for dental care?
A. As of that day, he did not.
Q. And do you -- do you know of anything in the file or chart that indicates that he changed his mind about not wanting to be referred out for dental care?
A. No.
Q. And then lastly, because I don't think we got up until this point, I'm showing you what I've got on the screen and I understand to be a copy of your written report in this case.
Do you see that?
A. Yes.
MR. JONES: Do you -- Steve, do you know what number we left off on? I think maybe 89?
MR. WEIL: Hold on one second. 89 is

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the last one.
MR. JONES: So we'll mark this as Exhibit 90.
(Exhibit 90 was marked for identification.)
Q. (BY MR. JONES:) Doctor, is this, in fact, and I can scroll through it if you'd like, but is this a complete copy of your report in this case?
A. That's what it looks like.
Q. And at the back end of it is your CV, correct?
A. Yes.
Q. And this is actually a CV from January of this year, correct?
A. Yes.
Q. And your January 2024 CV, is that a complete and current copy of your CV?
A. (No audible response.)
Q. I'm sorry, did you answer?
A. What was the question?
Q. The CV that's at the back of your report, Exhibit 90, is that a complete and current copy of your curriculum vitae?
A. It looks like it, yes.

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MR. JONES: Thank you, Doctor.
I don't have any other questions.
MR. CASSERLY: Can you stop sharing?
MR. JONES: Yes.

EXAMINATION

BY MR. CASSERLY:
Q. Good afternoon, Doctor. My name is John Casserly. I'm the attorney for USA Medical. My plane leaves in less than ninety minutes, so I have a couple of questions to start out.
I will not be asking you for examples unless I ask you for examples. Okay? Do you appreciate the -- I'm going to start over. And I'm also not going to ask you for reasons for the answers to my questions unless I say why.
Are those fair requests that I can make of you at this point?
A. Sure.
MR. WEIL: Objection.
MR. CASSERLY: Okay.
Q. (BY MR. CASSERLY:) You have a business that you own called TFS Correctional Consultants; is that correct?
A. Yes.

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Q. And you used to own a company with Badger in the name?
A. Yes.
Q. Is that right?
A. Yes.
Q. Can you give me the full name of the Badger business once more, please?
A. Badger Medical, PA.
Q. PA?
A. Yeah. Professional association.
Q. Okay. What kind of business organization was Badger Medical, PA?
A. It was a professional association. It was a corporation.
Q. Okay. I'm going to start asking, have you ever owned any other businesses besides those two?
A. No.
Q. Okay. Were you the sole owner of Badger? I'm going to use the shortened version, just Badger.
Were you the sole owner of Badger?
A. For most of its life I was because Idaho law required that a -- that such a company be owned only by a physician.

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Q. Okay.
A. Later when Idaho changed its law, my wife -- the short answer, my wife was a co-owner at the time of the sale.
Q. Not to be pedantic, your Honor -- Doctor, although I think that's what I do for a living, I would have said that the answer to that -- short answer to that question would have been no because I asked you if you were always the sole owner.
A. Okay.
Q. I didn't want to know why or under what circumstances you weren't the sole owner.
Would you agree that one of the main reasons for forming a corporation rather than running a business as a sole proprietorship is to obtain the liability limitations inherent in corporate ownership, right?
A. That's probably a little over my head. That isn't why I set up my corporation, but not something --
Q. Why -- why -- I'm sorry. I did not mean to speak over you.
Please finish.
A. I think I'm done.

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Q. Okay. Why did you set up a corporation rather than proceed as a sole proprietorship --
A. On the advice --
Q. -- for Badger?
A. On the advice of my attorney.
Q. Do you remember why your attorney told you that it was a good idea to form Badger as a corporation rather than run it as a sole proprietorship?
MR. WEIL: Okay. Hold on.
That's a privileged question. Privileged legal advice, so I'm going to instruct Dr. Keller not to answer.
MR. CASSERLY: I think my question was whether he remembered why, which wouldn't be privileged.
Wouldn't you agree?
MR. WEIL: Okay. Well, on that limited answer, that's fine.
THE WITNESS: Yes.
Q. (BY MR. CASSERLY:) Do you remember, Doctor?
A. Yes.
Q. Okay. Badger had a professional liability insurance policy with a limit of one

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million dollars for each claim.
Is that your best recollection?
A. Yes.
Q. Thinking back to the years that you owned Badger, do you remember, as you sit here, whether you kept retained earnings in the accounts of Badger year over year?
A. Yes.
Q. And do you have a memory of how much you left in Badger -- and a generalization or your best estimate of average at this point would be great -- year over year, when you owned Badger how much you would leave in there as profit?
A. Yes.
Q. How much would that be on average, your best estimate of average?
A. Zero.
Q. And that's because at the end of each year you would take the profits in order to avoid income tax on that; is that right? Corporate income tax?
A. Well, I assume that's the reason. We did it on the advice of our accountant, but I believe that the main reason was to avoid income tax.

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Q. Okay. I apologize for these gaps when I'm the one who's been whining about time, but I'm skipping over parts of my outline that I don't need, so....
I'd like to pose to you a hypothetical question about something that could have happened when you owned Badger.
If Badger had been sued by a patient inmate, and that inmate had received a verdict and judgment against Badger for millions of dollars more than your insurance policy, you'd agree that Badger, under that circumstance, would not have had sufficient capital to pay that judgment, would they?
A. Well, in this hypothetical, that is correct.
Q. Okay. Did Badger observe all the appropriate corporate formalities that you're aware of?
A. Yes.
Q. Okay. Do you have copies of meeting minutes from each year's shareholder meetings?
A. Yes.
Q. And meeting minutes of each year's board meetings?

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A. Yes.
Q. Okay. Have you continually insured that Badger's filing requirements with the State of Idaho have been met?
A. They were -- well, Badger doesn't exist anymore, but until it was dissolved, yes.
Q. Okay. Did Badger hold -- did Badger issue shares of stock?
A. One. One share.
Q. Okay. And who held that share of stock?
A. Me.
Q. Okay. Did Badger pay any money to you, the shareholder, in the form of dividends or did you take all proceeds as payroll?
A. No dividends, if I remember correctly.
Q. Okay. Did Badger have any officers or directors besides yourself?
A. No.
Q. Do you still have records in your possession that discuss the corporate formalities of the existence of Badger?
A. I don't believe so. I think that they went with the company that purchased Badger. I think all of that went with them.

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Q. Okay. Looking back on your ownership of Badger, even though there could have been a circumstance where a judgment against Badger would have left it unable to satisfy that judgment creditor, a theoretical possibility that we discussed, you don't believe that Badger was a mere facade of a corporation, do you?
MR. WEIL: Object to form.
THE WITNESS: I don't understand the question.
Q. (BY MR. CASSERLY:) Sure.
You believe that Badger was at all times in good faith operating as a corporate business, right?
A. Yes.
Q. You don't -- you wouldn't agree if someone accused you of sanctioning a fraud upon creditors with your ownership of Badger, right?
A. Well, it never happened, so I never had that -- never had to cross that bridge.
Q. Okay. Are you currently the sole owner of TFS Correctional Consultants?
A. Yes.
Q. And TFS is also a corporation, right?
A. Yes. I believe so.

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Q. And does TFS have a policy of professional liability insurance?
A. No. I don't believe so.
Q. Okay. Does TFS have more than a nominal amount of financial corporate assets, say more than ten thousand dollars maintained in its accounts?
A. No.
Q. But you do keep enough money in TFS to pay your debts, right?
A. Yes.
Q. Do you have any -- okay.
Does TFS observe all appropriate corporate formalities?
A. Yes.
Q. Do you have meeting minutes of each year's shareholder meeting?
A. I'm not sure what the corporate formalities are for TFS because I'm not sure exactly how it's structured. That's not my department, so I'm not sure. I don't -- I'm not sure even that it is a corporation. It might not be. I don't know.
Q. One second here. If the Idaho Secretary of State's website says that TFS Correctional Consultants is a general business corporation, would you have any reason to disagree with that?

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A. No. But, yes, I don't have any reason to disagree with that.
Q. Thank you.
Do you have meeting minutes of each year's board meetings?
A. I don't know.
Q. Okay. I don't think I got an answer to my previous question about whether you had copies of meeting minutes of each year's shareholder meetings.
A. I don't know.
Q. Okay. Have you made sure that TFS's filing requirements with the State of Idaho have been met?
A. Well, between my accountant and my attorney, I believe that all that's taken care of.
Q. Okay. If that same website at the Idaho Secretary of State's office indicates that TFS Correctional is inactive, dash, dissolved administrative, would you have any reason to disagree with that?
A. No, I don't. I don't know.
Q. Okay. You would disagree if someone accused you and TFS of -- of sanctioning a fraud, wouldn't you?
A. Yes. I would disagree with that.

Q. Okay. You don't believe that your operation of TFS promotes any injustice?

A. No.

MR. CASSERLY: Okay. Doctor, you have been very understanding of my anxiety about catching my plane and asking sharply worded and sounding questions. I apologize for that, and I have no further questions.

MR. WEIL: Okay. I think that's it for all the defendants, right?

MR. CASSERLY: Yes.

MR. KAFKA: Take a quick break if we could go off the record.

(Discussion off the record.)

THE COURT REPORTER: Mr. Casserly, what do you need with your transcript order?

MR. WEIL: Okay.

MR. CASSERLY: Okay.

MR. WEIL: Thanks.

MR. CASSERLY: I know we're not done. I'm going to listen by phone, but I would like just a searchable PDF with scanned PDF exhibits.

MR. WEIL: Okay. So Dr. Keller, you can turn off the mike and the camera real quick, and I'm going to do the same, and let's just take a break

and we'll reconvene for any questions.

(A brief recess was had.)

EXAMINATION

BY MR. WEIL:

Q. Okay. Dr. Keller, would you pull up your report, please, and turn to pages -- page 19 and 20?

A. Okay. I'm ready.

Q. Okay. You were asked -- you talked about medical care. I'm just reading from the first time -- the medical case I reviewed in this report, both within the Monroe County Jail and at other facilities, bear a striking resemblance to Ms. Boyer's case.

Is that -- I'm sorry, there's some sort of alarm going off. I'll be right back, I apologize.

(Pause in the proceedings.)

Q. (BY MR. WEIL:) Dr. Keller, I apologize for the interruption there.

The discussion you have of the outside cases, does that form a basis for the opinions you offer regarding the pattern of care.

A. Yes.

Q. Was that independent of your review -- well, describe the relationship between that and the review of the Monroe County cases in terms of the basis of your description or pattern of care?

THE COURT REPORTER: Counsel, you're going to have to speak up.

Q. (BY MR. WEIL:) Sure. I'll ask it -- did you hear the question, Dr. Keller?

A. I didn't hear the question all the way. I'm sorry.

Q. Okay. Let me -- I've got to turn something up here.

Did the cases involving outside medical care outside of Monroe County form a basis for your opinion about there being a pattern of improper medical care?

A. Yes.

Q. Was that the case whether or not regardless of who -- did that depend or was it independent of the Monroe County cases to be reviewed?

MR. JONES: Objection to form.

MR. WEIL: What's the objection?

MR. JONES: I don't understand what you're asking him.

MR. WEIL: Okay.

Q. (BY MR. WEIL:) Dr. Keller, can you try to answer the question?

A. It was an independent verification of my opinions, and it was probably in some way stronger because they were all deaths. So they were all mortality reviews rather than morbidity reviews, which were the majority of the Monroe County cases.

Q. If we just set aside all of the Monroe County cases and you looked -- if we're considering just the outside cases, is your conclusion about the pattern, the observations you made here, would that apply?

A. Yes.

Q. Okay. You were asked about statistical significance of your -- well, let me -- would you turn to page 9, please, Dr. Keller, of your report?

A. Sure.

Q. And turn -- if you'd read, there's review of records, care of other patients, and the second paragraph beginning: I have conducted.

Do you see that?

A. I have conducted this review in the manner of mortality and morbidity in signal event

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reviews.
Q. That's the one. If you read that paragraph real quick and I have a question.
A. Do you want me to read it out loud?
Q. You don't have to, no.
A. Yes, I've read it.
Q. Okay. Did this review -- did the review you conducted here depend on statistical measures of care provided among the other care provided at either ECH more broadly or the Monroe County Jail?
A. No. As I said before, I never intended to do a statistical analysis. I was doing an analysis more along the lines of a mortality and morbidity review where the goal is to identify problems that were amenable to correction.
Q. You were asked several times -- I think that you were asked several times about calling a medical staff person an LPN versus an R.N.
Do you remember that?
A. Yes.
Q. For your purposes in conducting your analysis in this for your report, did the distinction between LPN and R.N. matter for the cases you reviewed?
A. No.

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Q. Why not?
A. Because I wasn't looking at the difference of scope of practice between an LPN and an R.N. I was looking at the scope of practice of a nurse versus an advance practice nurse or other kind of practitioner.
Q. Do you remember being asked about six years of medical records?
A. Yes.
Q. Referring to the overall universe?
A. Yes.
Q. What's your understanding of the universe of medical records that were gathered at the Monroe County Jail for your review?
A. We had one year of review, one year of medical records. Some -- we had a few -- there were a few cases beyond that, and some of the records that I got included that bookings from before. So a patient that had been booked in the year that we got them had also been booked in previous years.
Q. Was there a -- did you have an understanding or were you provided with a full six years of medical records for the jail?
A. No. As I understand it, there was one year of medical records provided.

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MR. JONES: Do you recall -- I believe you referred to the spreadsheet that you had and the -- well, let me ask you this: In your experience with the jail, is it your -- about what portion of folks have medical issues requiring sustained medical attention at all?
MR. WEIL: Objection to form.
THE WITNESS: I don't know what the percentage is. Jail -- people incarcerated in jail tend to be younger and healthier than the population at large.
As a group, there are a lot of healthy young men who have no medical problems and never have medical complaints. What percentage that is, I'm not sure.
Q. (BY MR. WEIL:) Is it the case -- would you expect a lot of people to require medical care going in -- well, strike that.
How many of those people just never -- of the group you described, is it a large percentage who don't ever get medical care at all in jail, or do all of them end up getting medical care?
MR. JONES: Objection to form.
MR. KAFKA: Join.
MR. WEIL: What's the objection?

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MR. JONES: I'm not sure. I think the question was vague as to what group of incarcerated people you're asking him about.
MR. WEIL: Okay.
THE WITNESS: Are you waiting for me to answer?
MR. WEIL: No. I'm trying to address the objection so we can get out of here.
Q. (BY MR. WEIL:) I'm showing you the spreadsheet, Dr. Keller, that has been referred to a few times. Do you see column F with the number designation there?
A. Yes.
Q. Okay. And after -- there's a hundred and twenty that get four or higher, right?
A. Yes.
Q. Okay. And then the rest, just scrolling down here, are twos or ones, and then there's some change at the bottom.
Do you see that?
A. Yes.
Q. Okay. Do you have an understanding of what those lower numbers mean?
A. There are a lot of people who come to jail who have no medical problems and never make a

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medical request. So the only time they see medical is at intake, and then if they're there long enough at a year, regularly scheduled medical exams, and then any time they put in a request to see medical, but many never put in a request to see medical.

Q. Is that consistent with your experience as a correctional health care provider in terms of there being a large percentage of people who don't request medical care at all?

A. Yes.

Q. And so would it be -- well, strike that.

Dr. Keller, if you turn to page 6 of your report. Let me know when you're there.

A. Yes, I'm there.

Q. Okay. So I'm looking at the second paragraph in staffing because when a patient complains of chest pain, abdominal pain, or any other nontrivial complaint.

Do you see that?

A. Yes.

Q. And you and Mr. Jones had an extended conversation about that.

And abdominal pain is nontrivial why?

A. Abdominal pain is nontrivial because it has potential serious consequences of death or

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morbidity, and people with abdominal pain can get really sick.

Q. Would that be etiology of abdominal pain? Is that a serious etiology? Is that what you're describing?

A. What I'm describing is that the broad category of abdominal pain contains a large number -- the broad category of abdominal pain contains a large --

MR. WEIL: John, I don't think you're on mute. Let's just go ahead, Dr. Keller. Sorry about that.

THE WITNESS: The large category of abdominal pain contains a lot of things on the differential diagnosis that can cause serious harm; appendicitis, bowel obstructions, many, many things like that, so more than other types of complaints, there's a higher likelihood of someone having a serious outcome.

Q. (BY MR. WEIL:) Is that -- is that generally the reason you would include chest pain there as well?

A. Yes.

Q. Okay. And so those both have --

MR. CASSERLY: I'm sorry, I just see

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that I was not on mute, but I have to send you all through a metal detector, if you'll give me less than one minute without asking a question.

MR. WEIL: Sure.

MR. CASSERLY: Thank you.

(Pause in the proceedings.)

MR. CASSERLY: Thank you. You've all been X-rayed.

Go ahead.

Q. (BY MR. WEIL:) I think the question that I had while you were describing abdominal pain as having a number of serious etiologies -- and that's etiology for the court reporter.

The same would be true of chest pain; is that correct?

A. Yes.

Q. And is it potentially serious etiology that makes a complaint nontrivial?

A. Well, that's one of the things that makes a complaint nontrivial. Another that makes it nontrivial is that the patient asks to be -- for an evaluation. And another thing is that the -- the encounter ends up with a prescription of a legacy medication.

But of those, probably the most

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important is this one, the complaints that there are -- complaints that have a higher possibility of serious or negative outcomes.

Q. When we were -- if you turn to page 18 and 19 of your report, paragraphs 9, 10, and 11, did you see those three cases there, Dr. Keller?

A. Yes.

Q. Okay. I think when we were going over this yesterday, you identified those as cases that you reviewed, but they weren't in the documents listed on page 2 of your report; is that right?

A. That is correct.

The list of cases that I reviewed did not include those, and I did review them obviously since they are in the report.

Q. So did you review documents underlying those three cases Listale (phonetic), Riggin, and Hinkle?

A. Yes.

MR. WEIL: Okay. Doctor, that's all I have.

Thank you.

MR. JONES: Doctor, there's really just one thing I want to follow up on, and that's in reference to this Excel spreadsheet again that

Mr. Weil asked you about briefly.

FURTHER EXAMINATION

BY MR. JONES:

Q. Do you know what the difference between a five and a four in column F is?

A. As I understand it, the -- it's a difference in possibility of a medical -- bad medical event.

Q. And how did you gain that?

A. Five would be the highest possibility, four would be next, all the way down to one being zero.

Q. And how did you gain that understanding?

A. Mr. Weil or one of his team told me.

Q. And when was that?

A. When I got the -- when I got this when they sent it to me.

Q. Because I understood you when I was asking you questions before to not know what column F described.

A. Oh, no, no, no. I don't know what column A, B, and D -- well or -- but F, yes, I did. I don't think that's true. We'll have to go back to

the transcript, but I knew what F described.

Q. Fair enough. Fair enough.

And do you know what the dividing line between a four and a five is or between a four and a three is?

A. No.

Q. And is that true of the lines between each of the categories, one through five?

A. Yes.

MR. JONES: That's all I had.

Thank you.

MR. WEIL: Anyone else?

MR. KAFKA: One second, please.

MR. CASSERLY: Casserly has no follow up.

MR. KAFKA: No. That's it.

THE COURT REPORTER: Counsel, I need to know -- Mr. Casserly, what do you want with your transcript order?

MR. CASSERLY: Just a searchable PDF with PDF exhibits attached.

THE COURT REPORTER: Mr. Kafka?

MR. KAFKA: I'll take the same.

THE COURT REPORTER: Mr. Jones?

MR. JONES: Same.

THE COURT REPORTER: Mr. Weil?

MR. WEIL: No copy at this time -- no, we'll take a copy. What am I saying? Just a searchable PDF, no index, and exhibits. Same thing.

THE COURT REPORTER: And Mr. Kafka, you're e-mailing the exhibits to me, correct?

MR. KAFKA: I will, yes.

THE COURT REPORTER: Do you want me to give you the e-mail address real quick?

MR. KAFKA: No, I actually copied it already. Thank you, though.

THE COURT REPORTER: Perfect.

And did you want to read and sign your transcript or waive signature?

THE WITNESS: Yes. Read and sign.

(Whereupon, the videoconference deposition concluded at 6:21 p.m.)

* * * * * *

REPORTER'S CERTIFICATE

STATE OF IDAHO)
) ss.
COUNTY OF BONNEVILLE)

I, DiAnn Erdman Prock, CSR, CCR, a duly commissioned Notary Public in and for the State of Idaho, do hereby certify:

That prior to being examined, JEFFREY KELLER, M.D., FACEP, FACCP, the witness named in the foregoing videoconference deposition, was by me duly sworn to testify to the truth, the whole truth, and nothing but the truth;

That said videoconference deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to typewriting under my direction, and that the foregoing transcript contains a full, true, and verbatim record of said videoconference deposition spoken in my direct presence or received by me via electronic transmission.

I further certify that I have no interest in the event of the action.

WITNESS my hand and seal this 28th day of March, 2024.

DiAnn Erdman Prock
COMMISSION NO. 51352
NOTARY PUBLIC
STATE OF IDAHO

DiAnn Erdman Prock
Idaho CSR SRL 963, CCR
Notary Public in and for
the State of Idaho

My commission expires November 26, 2025.

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LEXITAS LEGAL

April 8, 2024

STEPHEN H. WEIL, ESQUIRE

LOEVY & LOEVY

311 North Aberdeen Street, 3rd Floor

Chicago, Illinois 60607

IN RE: Gregory Boyer et al v Advanced Correctional Healthcare Inc et al

Dear Mr. Weil,

Please find enclosed a copy of the deposition of JEFFREY KELLER, M.D., taken on MARCH 19, 2024 in the above-referenced case. Also enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page to our office at 711 N 11th Street, St. Louis, MO 63101 for filing prior to trial date.

Sincerely,

DiAnn Erdman Prock

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Enclosures

ERRATA SHEET

Witness Name: JEFFREY KELLER, M.D.

RE: Gregory Boyer et al v Advanced Correctional Healthcare Inc et al

Date Taken: MARCH 19, 2024

Page #_____ Line #_____

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Should read: _____

Reason for change: _____

Witness Signature: _____

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STATE OF _____)

COUNTY OF _____)

I, JEFFREY KELLER, M.D., do hereby certify:

That I have read the foregoing deposition;

That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;

That having made such changes thereon, I hereby subscribe my name to the deposition.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this _____ day of _____, 20___, at _____.

_____

JEFFREY KELLER, M.D.

_____

NOTARY PUBLIC

My Commission Expires:

B

Q

Z